

# NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 175 Water Street, 15<sup>th</sup> Floor, New York, NY 10038

(212) 458-5000

(a capital stock company, herein referred to as the Company)

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Policyholder: Diocese of Palm Beach

Policy Number: SRG 0009151977

For inquiries, information about coverage or for  
assistance in resolving complaints:

National Union Fire Insurance Company of  
Pittsburgh, Pa.: 1-800-551-0824

## BLANKET ACCIDENT INSURANCE

### CERTIFICATE OF COVERAGE

This Certificate of Coverage describes blanket accident insurance coverage provided to eligible persons of the policyholder named above (herein called the Policyholder) while those persons are participating in Covered Activities.

#### **Who Is Eligible**

The persons eligible for coverage under the above referenced blanket accident insurance policy (herein called the Policy) issued to the Policyholder are: All enrolled students of the school or school district enrolled in the Optional Voluntary 24 Hour Accident Plan.

(Grades PreK-12 and Daycare) (Includes enrolled and non-enrolled students participating in summer camps, RCIA program, youth programs, CCD, Catholic Charities).

#### **What Activities Are Covered**

Covered Activity/ies are: While participating in a sport and/or activity (excluding Senior High interscholastic football and Senior High interscholastic sports), that is not covered under a compulsory plan provided by the Policyholder.



President



Secretary

**PLEASE READ THIS CERTIFICATE OF COVERAGE CAREFULLY**

**THIS COVERAGE HAS A DEDUCTIBLE**

**EXCESS INSURANCE.**

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## Benefit Schedule

<b>Accidental Death Benefit</b>	
Maximum Amount:	\$15,000
<b>Accidental Dismemberment Benefit</b>	
Maximum Amount:	\$30,000
<b>Accident Medical Expense Benefit</b>	
Overall Accident Medical Expense Maximum Amount:	\$25,000
<b>Coinsurance:</b>	65%
<b>Maximum Amount for Physical Therapy:</b>	\$35 per Day
<b>Maximum Number of Visits:</b>	5
Note: Expenses charged to the maximum for the above services are also subject to the Overall Accident Medical Expense Maximum Amount shown above.	
<b>Maximum Amount for Emergency Room/Ambulatory Medical/Surgical Center:</b>	\$1,500
Note: Expenses charged to the maximum for the above Emergency Room/Ambulatory Medical/Surgical Center are also subject to the Overall Accident Medical Expense Maximum Amount shown above.	
<b>Maximum Amount for Ambulance:</b>	\$500
Note: Expenses charged to the maximum for the above ambulance are also subject to the Overall Accident Medical Expense Maximum Amount shown above.	
<b>Dental Maximum Amount per tooth:</b>	\$250 per accident
Note: Expenses charged to the maximum for the above Dental services per tooth are also subject to the Overall Accident Medical Expense Maximum Amount shown above.	
<b>Maximum Amount for Deferred Dental Treatment Benefit:</b>	\$600 per accident
Note: Expenses charged to the maximum for the above Deferred Dental Treatment services are <i>not</i> subject to the Overall Accident Medical Expense Maximum Amount shown above.	
<b>Heart and/or Circulatory Benefit</b> <i>(This benefit is not payable in addition to the Accidental Death Benefit.)</i>	
Maximum Amount:	\$15,000

The Maximum Amounts are used to determine amounts payable under each Benefit. Actual amounts payable will not exceed the maximums, and may be less than the maximums under circumstances specified in the Policy.

## Definitions

**Covered Activity(ies)** – means While participating in a sport and/or activity (excluding Senior High interscholastic football and Senior High interscholastic sports), that is not covered under a compulsory plan provided by the Policyholder.

**Hospital** – means a facility that: (1) is operated according to law for the care and treatment of injured and sick people; (2) has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis or is accredited by the Joint Commission on the Accreditation of Hospitals, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities; (3) has 24-hour nursing service by registered nurses (RNs) and (4) is supervised by one or more Physicians. A Hospital does not include: (1) a nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care; (2) a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing, or other section of the hospital that is used for such purposes; or (3) any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, unless You are legally required to pay for services in the absence of insurance.

**Injury** – means bodily injury: (1) which is sustained as a direct result of an unintended, unanticipated accident that occurs while the injured person's coverage under the Policy is in force; (2) which occurs while such person is participating in a Covered Activity; and (3) which directly (independent of sickness, disease, mental incapacity, bodily infirmity or any other cause) causes a covered loss.

**Immediate Family Member** – means a person who is related to You in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild).

**Medically Necessary** – means that a Covered Service is: (1) essential for diagnosis, treatment or care of the Injury for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) is ordered by a Physician and performed under his or her care, supervision or order.

**Physician** – means a licensed practitioner of the healing arts acting within the scope of his or her license who is not: 1) You or 2) an Immediate Family Member.

**Usual and Customary Charge(s)** – means the charge which is the smallest of: (a) the actual charge of the Covered Service; (b) the charge usually made for a Covered Service by the provider who furnishes it, (c) the survey by Ingenix of prevailing charges made for a Covered Service in the geographic area by those of similar professional standing, the results of which are used to develop a range of fees for each service.

“Geographic area” means the three digit zip code in which the service, procedure, devices, drugs, treatment or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charges for a like treatment, service, procedure, device, drug or supply

With respect to item (d) above, Usual and Customary Charges means the 80<sup>th</sup> percentile of the payment system in effect on the Effective Date shown in the Benefit Schedule.

**You, Your** – means a person: (1) who is a member of an eligible class of persons as described in the Who is Eligible section of this Certificate of Coverage; (2) for whom premium has been paid; (3) while covered under the Policy; and (4) who has enrolled for coverage under the Policy, if required.

## **Your Effective and Termination Dates**

**Effective Date.** Your coverage under the Policy begins on the latest of: (1) the Policy Effective Date; (2) the date for which the first premium for Your coverage is paid; (3) the date You become a member of Diocese of Palm Beach; or (4) if individual enrollment is required, the date written enrollment is received by the Policyholder.

A change in Your coverage under the Policy due to a change in Your eligible class, Covered Activity or election of enrollment option becomes effective on the later of (1) the date the change in Your eligible class, Covered Activity or election of enrollment option occurs; (2) if the change requires a change in premium, the date the first changed premium is paid; or (3) if individual enrollment for the change is required, the date the written enrollment form requesting the change is received by the Policyholder. However, a change in coverage applies only with respect to accidents that occur once the change is effective.

**Termination Date.** Your coverage under the Policy ends on the earliest of: (1) the date the Policy is terminated; (2) the end of the period for which premiums have been paid; (3) the date You cease to be a member of Diocese of Palm Beach; or (4) the date the Insured requests, in writing, that his or her coverage be terminated.

The Company may terminate this Policy by giving 45 days advance notice in writing to the Policyholder.

Termination of coverage will not affect a claim for a covered loss that occurs either before or after such termination if that loss results from an accident that occurred while Your coverage was in force under the Policy.

## Description of Benefits

The Maximum Amounts shown in the Benefit Schedule are used to determine amounts payable under each Benefit.

**Accidental Death Benefit.** If You suffer an Injury that results in death within 365 days of the date of the accident that caused the Injury, the Company will pay You 100% of the Accidental Death Maximum Amount.

**Accidental Dismemberment Benefit.** If You suffer an Injury that results, within 365 days of the date of the accident that caused the Injury, in any one of the Losses specified below, the Company will pay the percentage of the Accidental Dismemberment Maximum Amount shown below for that Loss:

For Loss of:	Percentage of Maximum Amount
Both Hands or Both Feet .....	100%
Sight of Both Eyes .....	100%
One Hand and One Foot .....	100%
One Hand and the Sight of One Eye.....	100%
One Foot and the Sight of One Eye.....	100%
Speech and Hearing in Both Ears.....	100%
One Hand or One Foot .....	50%
The Sight of One Eye .....	50%
Speech or Hearing in Both Ears .....	50%
Hearing in One Ear.....	25%
Thumb and Index Finger of Same Hand.....	25%

“Loss” of a hand or foot means complete severance through or above the wrist or ankle joint. “Loss” of sight of an eye means total and irrecoverable loss of the entire sight in that eye. “Loss” of hearing in an ear means total and irrecoverable loss of the entire ability to hear in that ear. “Loss” of speech means total and irrecoverable loss of the entire ability to speak. “Loss of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

If You sustain more than one Loss as a result of the same accident, only one amount, the largest, will be paid.

**Exposure and Disappearance.** If by reason of an accident occurring while Your coverage is in force under the Policy, You are unavoidably exposed to the elements and as a result of such exposure suffer a loss for which a benefit is otherwise payable under the Policy, the loss will be covered under the terms of the Policy.

If Your body has not been found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which You were an occupant while covered under the Policy, then it will be deemed, subject to all other terms and provisions of the Policy, that You have suffered accidental death within the meaning of the Policy.

**Accident Medical Expense Benefit.** If You suffer an Injury that, within 90 days of the date of the accident that caused the Injury, requires You to be treated by a Physician, the Company will pay the coinsurance percentage of the Usual and Customary Charges incurred for Medically Necessary Covered Accident Medical Services received due to that Injury, up to the Maximum Amount per person. Benefits are payable 52 weeks after the date of the accident causing the Injury.

No expenses paid under this Benefit will be payable under any other Benefit.

*Covered Accident Medical Services(s) – means*

1. services of a Physician;
2. private duty nursing by a registered nurse (R.N.) or Licensed Practical Nurse (LPN);
3. laboratory tests;
4. radiological procedures;
5. anesthetics and the administration of anesthetics;
6. blood, blood products and artificial blood products, and the transfusion thereof;
7. physical therapy except that while Hospital confined, such therapy is payable only up to the Physical Therapy Maximum in the Benefit Schedule and an office visit connected with any such service is payable up to the per Day per Visit Maximum in the Benefit Schedule;
8. occupational therapy;
9. rental of Durable Medical Equipment;
10. artificial limbs, artificial eyes or other prosthetic appliances;
11. medicines or drugs administered by a Physician or that can be obtained only with a Physician's written prescription;
12. use of an Ambulatory Medical Center or Ambulatory Surgical Center;
13. Hospital's most common charge for semi-private room and board (or room and board in an intensive care unit); Hospital ancillary services (including use of the operating room or emergency room);
14. ambulance service to or from a Hospital up to the Ambulance Maximum in the Benefit Schedule;
15. Any inpatient Hospital, Ambulatory Surgical Center and general anesthesia services or charges due to Injury if You are:
  - (a) under 8 years of age or it has been determined by a licensed dentist and Your Physician that you require necessary dental treatment or surgery in a Hospital or Ambulatory Surgical Center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or
  - (b) You have one or more medical condition that would create significant or undue medical risk for You in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center.

Deferred Dental Treatment Benefits – If you suffer an Injury to sound, natural teeth and the required dental treatment for that Injury must be postponed to a date more than 52 weeks after the date of that Injury due to the physiological changes occurring to You as a growing child, the Company will pay the coinsurance percentage of the Usual and Customary Charges incurred for the dental treatment up to the Deferred Dental Treatment Maximum Amount shown in the Benefit Schedule and subject to the duration of the deferred dental treatment. Usual and Customary Charges incurred for Deferred Dental Treatment are covered only if they are incurred on or before Your 21<sup>st</sup> birthday; except that Usual and Customary Charges incurred for deferred root canal therapy are covered only if they are incurred within 104 weeks after the date of the Injury. No payment will be made for any deferred treatment unless a Physician submits a written certification that the treatment must be postponed for the reasons stated within this paragraph. Such certification must be submitted to the Company within 104 weeks after the accident.

**Extension of Dental Benefits.** The Company will continue to pay Dental Benefits for a specific dental injury following the termination of Your coverage under the Policy if all of the following conditions are met:

- (a) The course of treatment or dental procedures were recommended in writing by Your Physician or dentist and began in connection with a specific accident that occurred while Your coverage was in effect under the Policy.
- (b) The dental procedures were for other than routine examinations, prophylaxis, X-rays, sealants or orthodontic services.
- (c) Termination of your policy was not voluntary.

This Extension of Benefits will terminate on the earlier of:

- (a) The expiration of 90 days following Your termination of coverage; and
- (b) The date You become covered under the succeeding policy or contract providing coverage for similar dental procedures.

**EXCLUSIONS:** In addition to the standard exclusions under the Policy and any amendment thereto, Accident Medical Expense benefits are not payable for any expense for or resulting from any of the following:

- (1) repair or replacement of existing artificial limbs, artificial eyes or other prosthetic appliances or rental of existing Durable Medical Equipment unless for the purpose of modifying the item because Injury has caused further impairment in the underlying bodily condition;
- (2) new, or repair or replacement of, dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums, except for repair or replacement of sound natural teeth damaged or lost as a result of Injury up to the Dental Maximum shown in the Benefit Schedule;
- (3) new eye glasses or contact lenses or eye examinations related to the correction of vision or related to the fitting of glasses or contact lenses, unless Injury has caused impairment of sight; or repair or replacement of existing eyeglasses or contact lenses unless for the purpose of modifying the item because Injury has caused further impairment of sight;
- (4) new hearing aids or hearing examinations unless Injury has caused impairment of hearing; or repair or replacement of existing hearing aids unless for the purpose of modifying the item because Injury has caused further impairment of hearing;
- (5) rental of Durable Medical Equipment where the total rental expense exceeds the usual purchase expense for similar equipment in the locality where the expense is incurred (but if, in the Company's sole judgment, Accident Medical Expense benefits for rental of Durable Medical Equipment are expected to exceed the usual purchase expense for similar equipment in the locality where the expense is incurred, the Company may, but is not required to, choose to consider such purchase expense as a Usual and Customary Covered Charge Accident Medical Expense in lieu of such rental expense;
- (6) any charge for medical care for which You are not legally obligated to pay;
- (7) care, treatment or services provided by You or by an Immediate Family Member;
- (8) routine physical exam and related medical services;
- (9) personal comfort or convenience items, such as Hospital telephone charges, television rental, or guest meals while confined in a Hospital;
- (10) elective treatment or surgery;
- (11) Experimental or Investigative treatment or procedures;
- (12) care, treatment or services provided by persons retained or employed by the Policyholder or for supplies, prescriptions or medicines paid for or reimbursable by the Policyholder or for which a charge is not made;
- (13) mental illness, psychological or psychiatric counseling of any kind, mental and nervous disease or disorders and rest cures;
- (14) educational or vocational testing or training;
- (15) treatment of Osgood-Schlatter's disease;
- (16) detached retina unless due to an Injury;
- (17) diagnostic tests or treatment, except due to infection which occurs directly from an accidental cut or wound or ingestion of contaminated food;
- (18) plastic or cosmetic surgery except for reconstructive surgery on an injured part of the body;
- (19) charges that are payable under motor vehicle medical benefits;
- (20) hernia;
- (21) any condition for which You are paid benefits under any Workers' Compensation Act or similar law.

**Definitions.** The following are additional definitions that apply to the Accident Medical Expense Benefit.

*Ambulatory Medical Center* – means a licensed facility providing ambulatory medical treatment, other than a Hospital, clinic or Physician's office.

*Ambulatory Surgical Center* –means a licensed facility providing ambulatory surgical treatment, other than a Hospital, clinic or Physician's office.

*Durable Medical Equipment* – refers to equipment of a type that is designed primarily for use, and used primarily, by people who are injured ( for example, a wheelchair or a hospital bed). It does not include items commonly used by people who are not injured, even if the items can be used in the treatment of Injury or can be used for rehabilitation or improvement of health (for example, a stationary bicycle or a spa).

*Experimental or Investigative* – means treatment, a device or prescription medication which is recommended by a Physician, but is not considered by the medical community as a whole to be safe and effective for the condition for which the treatment, device or prescription medication is being used, including any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice, and any of those items requiring federal or other government agency approval not received at the time the services are rendered.

*Mental Illness* – means any disturbance of emotional equilibrium, as manifested in maladaptive behavior and impaired functioning, caused by genetic, physical, chemical, biologic, psychological, or social and cultural factors. Also called emotional illness, mental/nervous disorder and psychiatric disorder.

*Total Disability/Totally Disabled* - means that while You are under the regular care of a Physician, you are unable to perform the material and substantial duties of Your occupation. However, if an occupational definition of Total Disability/Totally Disabled is not appropriate for You, Total Disability/Totally Disabled means that You are 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 You immediately prior to the accident.

**Heart and/or Circulatory Benefit.** If You suffer a heart and/or circulatory malfunction that results in death as a direct result of participating in a Covered Activity, the Company will pay the Accidental Death Benefit provided that the symptom(s) of such malfunction(s) is (are) first medically treated while the Policy is in force with respect to You and within 48 hours after such participation.

## Limitations

**Limitation on Multiple Benefits.** If You suffer one or more losses from the same accident for which amounts are payable under more than one of the following benefits provided by the Policy, the maximum amount payable under all of the benefits combined will not exceed the amount payable for one of those losses, the largest: Accidental Death Benefit, Accidental Dismemberment Benefit.

**Limitation on Multiple Covered Activities.** If Your Injury is caused by an accident that occurs while You are participating in more than one Covered Activity and if the same benefit applies to You with respect to more than one such Covered Activity, the Maximum Amount for that benefit for You for that accident will be determined as though the accident occurred while You were participating in only one such Covered Activity, the one with the largest Maximum Amount for that benefit for You.

## Exclusions

No coverage shall be provided under the Policy and no payment shall be made for any loss resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks: (1) suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury or autoeroticism; (2) sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from any of these; (3) Your commission of or attempt to commit a crime; (4) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including to diabetes; (5) declared or undeclared war, or any act of declared or undeclared war, except if specifically provided by the Policy (this exclusion will not act to deny coverage an

Insured as a result of a terrorist act unless that Insured was involved in the implementation of or participation in the act); (6) participation in any team sport or any other athletic activity, except participation in a Covered Activity; (7) full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Unearned premium for any period for which You are not covered due to Your active duty status will be refunded) (Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded). (8) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if You are: (a) riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or (b) performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or (c) riding as a passenger in an aircraft owned, leased or operated by the Policyholder or Your employer; (9) You while under the influence of intoxicants while operating any vehicle or means of transportation or conveyance; (10). You while under the influence of drugs unless taken under the advice of and as specified by a Physician; (11) the medical or surgical treatment of sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from the treatment; (12) stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm; (13) any condition for which You are paid benefits under any Workers' compensation Act or similar law; (14) You while 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; (15) any loss incurred while outside the United States, its Territories or Canada.

### **Excess Benefits**

Accident Medical Expense benefits are payable only in excess of expenses payable under any other valid and collectible insurance.

Penalty for Non-Compliance. In the event that You are eligible under the Policy for benefits in excess of other coverage and You have other coverage that is primary under a health maintenance organization, preferred provider organization or similar health service program, a penalty will apply if You do not use the facilities or services of the health maintenance organization, preferred provider organization or similar health service program. In such case, the benefits otherwise payable under the Excess provision in the Policy will be reduced by 50%. This reduction shall not apply to You in connection with any treatment for which the health maintenance organization, preferred provider organization or similar health service program provides coverage as if You used the facilities or services of the health maintenance organization, preferred provider organization or similar health service program.

### **Subrogation and Right of Recovery**

As a condition to receiving Accident Medical Expense benefits under the Policy, You (or, if You are deceased, Your authorized representative) agree, except as may be limited or prohibited by applicable law:

1. to reimburse the Company for any such benefits paid to or on behalf of You, if such benefits are recovered, in any form, from any Third Party or Coverage; and
2. without limiting the preceding, that the Company is subrogated, for the purpose of the Company's recovery of any such benefits paid to or on behalf of You, to any and all claims, causes of action or rights that You have or that may rise against any Third Party who has or may have caused, contributed to or aggravated the Injury or condition for which You claim an entitlement to Policy benefits, and to any claims, causes of action or rights You may have against any Coverage for the Injury or condition for which You claim an entitlement to Policy benefits.

You agree that You will make a decision on pursuing any and all claims, causes of action and rights against any and all Third Parties and Coverage within 30 days of the date the Company requires that You provide Notice of Claim for the Injury or condition for which such Policy benefits are sought, and within such 30-day period will so notify the Company in writing. In the event You decide not to pursue a claim, cause of action or

right against a Third Party or Coverage, or fail to notify the Company of Your intent to do so within such 30-day period, You authorize the Company to pursue, sue, compromise or settle such claim, cause of action or right in Your name, authorize the Company to execute any and all documents necessary or pursue any such claim, cause of action or right, and agree to cooperate fully with the Company in the prosecution of any such claim, cause of action or right.

If You are a minor or not competent to make this agreement, the legal guardian of Your property makes the agreement on Your behalf as a condition to receiving Accident Medical Expense benefits under the Policy on Your behalf. If You have no guardian for Your property, the person or persons who, in the Company's opinion, have assumed the custody and support of the minor or responsibility for Your affairs, if you are not competent makes the agreement on Your behalf as a condition to receiving such benefits under the Policy on Your behalf.

The Company will not pay or be responsible, without its written consent, for any fees or costs associated with the pursuit of a claim, cause of action or right by You or on Your behalf against any Third Party or Coverage.

*Coverage* – means no fault motorist coverage, uninsured motorist coverage, underinsured motorist coverage, or any other fund or insurance policy (except the Policy and any fund or insurance policy providing the Policyholder with coverage for any claims, causes of action or rights You may have against the Policyholder).

*Third Party(ies)* – means any person, corporation or other entity (except You, the Policyholder and the Company).

### **Claims Procedures**

**Notice of Claim.** Written notice of claim must be given to the Company within 20 days after an Insured's loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the Company at AIG, Accident and Health Claims Division, P.O. Box 25987, Shawnee Mission, KS 66225, with information sufficient to identify the Insured, is deemed notice to the Company.

**Claim Forms.** The Company will send claim forms to the claimant upon receipt of written notice of claim. If such forms are not sent within 15 days after the giving of notice, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The notice should include the Insured's name, the Policyholder's name and the Policy number.

**Proof of Loss.** Written proof of loss must be furnished to the Company within 90 days after the date of the loss. If the loss is one for which the Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as the Company may reasonably require. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

**Payment of Claims.** Upon receipt of due written proof of Your death, payment will be made to Your beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

Upon receipt of due written proof of loss, payments for all other losses will be made to You. If You die before all payments due have been made, the amount still payable will be paid to Your beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

Upon receipt of due written proof of loss, benefit payments for charges You incur for covered medical services may be made to the provider at the Company's option. If You paid any such charges, the benefit payment for those charges will be made to You.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding \$1,000 may be made, at the Company's option, to any relative by blood or connection by marriage of the payee, who, in the Company's opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

Any payment the Company makes in good faith fully discharges the Company's liability to the extent of the payment made.

**Time of Payment of Claims.** Benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon the Company's receipt of due written proof of the loss; but in no event more than 45 days from the date the Company receives the due written proof of loss. Subject to the Company's receipt of due written proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

**Restriction on Denial of Claims.** A claim for payment for treatment, care, or services in a licensed hospital that is accredited by an accrediting organization whose standards incorporate comparable regulations required by this state may not be denied because such hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for treatment of physical disability. No claim for payment for medical care or treatment of a child in a licensed hospital which is nonprofit; which primarily provides diagnosis, treatment, or care for patients whose physical functions or movements are impaired by accident, disease, or congenital deformity; and which accepts patients for treatment without regard to race, color, national origin, sex, religion, or affiliation shall be denied because the hospital does not have facilities for major surgery or because the treatment and care are primarily of a charitable nature.

**Dental Claim Appeals.** If You have a claim denied as not Medically Necessary or have a claim payment based on an alternate dental service, in accordance with accepted dental standards for adequate and appropriate care, You will be provided an opportunity for an appeal to the Company's licensed dentist who is responsible for the Medical Necessity reviews under the Policy. The appeal may be by telephone and the Company's dentist must respond within 15 business days.

### **General Provisions**

**Entire Contract; Changes.** The Policy, the Master Application, and any attached papers make up the entire contract between the Policyholder and the Company. In the absence of fraud, all statements made by the Policyholder or any insured person will be considered representations and not warranties. No written statement made by You will be used in any contest unless a copy of the statement is furnished to You or Your beneficiary or personal representative.

No change in the Policy will be valid until approved by an officer of the Company. The approval must be noted on or attached to the Policy. No agent may change the Policy or waive any of its provisions.

**Physical Examination and Autopsy.** The Company at its own expense has the right and opportunity to examine the person of any individual whose loss is the basis of claim under the Policy when and as often as it may reasonably require during the pendency of the claim and to make an autopsy in case of death where it is not forbidden by law.

**Legal Actions.** No action at law or in equity may be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action may be brought after the expiration of the applicable statute of limitation from the time written proof of loss is required to be furnished.

**Conformity With State Statutes.** Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which the Policy is delivered is hereby amended to conform to the minimum requirements of those statutes.

**Workers' Compensation.** The Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.

**Clerical Error.** Clerical error, whether by the Policyholder or the Company, will not void the insurance of any Insured if that insurance would otherwise have been in effect nor extend the insurance of any Insured if that insurance would otherwise have ended or been reduced as provided in this Policy.

**Misstatement of Age.** If premiums for the Insured are based on age and the Insured has misstated his or her age, there will be a fair adjustment of premiums based on his or her true age. If the benefits for which the Insured is insured are based on age and the Insured has misstated his or her age, there will be an adjustment of said benefit based on his or her true age. The Company may require satisfactory proof of age before paying any claim.

**Beneficiary Designation and Change.** Your beneficiary(ies) is (are) the person(s) designated by You and on file with the Company.

If You are over the age of majority and legally competent, You may change Your beneficiary designation at any time, unless an irrevocable designation has been made, without the consent of the designated beneficiary(ies), by providing the Company with a written request for change. When the request is received, whether You are then living or not, the change of beneficiary will relate back to and take effect as of the date of execution of the written request, but without prejudice to the Company on account of any payment made by it prior to receipt of the request.

If there is no designated beneficiary or no designated beneficiary is living after Your death, the benefits will be paid, in equal shares, to the survivors in the first surviving class of those that follow: Your (1) spouse; (2) children; (3) parents; or (4) brothers and sisters. If no class has a survivor, the beneficiary is Your estate.

### **IMPORTANT**

If any conflict should arise between the contents of this Certificate of Coverage and the Master Policy SRG 0009151977, or if any point is not covered herein, the terms and conditions of the Master Policy will govern in all cases.