

Group Personal Accident Certificate



ZURICH AMERICAN INSURANCE COMPANY

1299 Zurich Way
Schaumburg, Illinois 60196

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

THIS INSURANCE EVIDENCED BY THIS CERTIFICATE PROVIDES ACCIDENT COVERAGE ONLY.

THE POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

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.

IN WITNESS WHEREOF, this Company has executed and attested these presents and, where required by law, has caused this **Certificate** to be countersigned by its duly Authorized Representative(s).

President

Corporate Secretary

PLEASE READ THIS CERTIFICATE CAREFULLY.

POLICYHOLDER: National Wellness & Fitness Association

POLICY NUMBER: GPA 8837399

POLICY INCEPTION: September 1, 2025

POLICY PERIOD: September 1, 2025, to Continuous

(All Insurance begins and ends at 12:01 a.m. at the **Policyholder's** Address)

PREMIUM: Payable Monthly

TABLE OF CONTENTS

Section I	SCHEDULE
Section II	ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE
Section III	DEFINITIONS
Section IV	HAZARDS
Section V	COVERAGES
Section VI	GENERAL EXCLUSIONS
Section VII	GENERAL LIMITATIONS
Section VIII	TERMINATION OF INSURANCE
Section IX	HOW TO FILE A CLAIM
Section X	PAYMENT OF CLAIMS
Section XI	GENERAL POLICY CONDITIONS

SECTION I – SCHEDULE

A. CLASSIFICATION AND ELIGIBILITY

1. Classification of Covered Persons

The following individuals are eligible to become **Covered Persons**:

Class I: **Members** of the **Policyholder** under the age of sixty-five (65) at time of enrollment, as on file with the Plan Administrator.

If a **Covered Person** suffers an **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.

2. Eligibility

You are eligible to become an **Insured** upon submission of completed enrollment material, if required:

Class I

Eligibility of **Your Dependents**:

Dependent Child(ren) of a Class I **Eligible Persons** are eligible to become **Covered Persons** if a parent becomes an **Insured**.

Spouse/Domestic Partner of Class **Eligible Persons** are eligible to become **Covered Persons** if the **Eligible Person** becomes an **Insured**. Such **Spouse/Domestic Partner** must be under age sixty-five (65).

A legally married **Spouse/Domestic Partner** will not be eligible for coverage as a **Dependent** if he or she is also an **Insured** under the **Policy**. If **You** and **Your** legally married **Spouse/Domestic Partner**, legally separated **Spouse/Domestic Partner**, or former **Spouse/Domestic Partner** are both **Insureds** under the **Policy**, only one may select a **Plan** covering their mutual **Dependents**.

B. REPORTING AND NOTICE ADDRESS(ES)

Claim Reporting:

Administrative Concepts, Inc.
P.O. Box 4000
Collegeville, PA 19426
(800) 410-9153
EDI Payor ID: 22384

C. SCHEDULE OF HAZARDS, COVERAGES AND BENEFITS

Plan 2

HAZARDS applicable to Class I **Contributory**:

Hazard
H-1 24 Hour Accident Protection

COVERAGES applicable to Class I **Contributory**:

Coverage	Benefit Amount
C-1 Accident Medical Expense Coverage:	
Accident Medical Expense Benefit	Maximum Benefit of \$7,500 per Covered Person per Accident subject to a \$0 Deductible per Covered Person per Accident .
C-3 Accidental Death Coverage:	
Accidental Death Benefit	Principal Sum \$10,000 as set forth in the Principal Sum Schedule.
Accidental Dismemberment and Plegia Benefit	Covered Loss of: 1. Both Hands or Both Feet: 100% of the Principal Sum 2. One Hand and One Foot: 100% of the Principal Sum

Coverage	Benefit Amount
	3. One Hand or One Foot plus the loss of Sight of One Eye: 100% of the Principal Sum 4. Sight of Both Eyes: 100% of the Principal Sum 5. Speech and Hearing in Both Ears: 100% of the Principal Sum 6. Speech or Hearing in Both Ears: 50% of the Principal Sum 7. One Hand; One Foot; or Sight of One Eye: 50% of the Principal Sum 8. Thumb and Index Finger of the Same Hand: 25% of the Principal Sum 9. Hearing in One Ear: 25% of the Principal Sum Plegia: 1. Quadriplegia (total paralysis of All Four Limbs): 100% of the Principal Sum 2. Triplegia (total paralysis of Three Limbs): 75% of the Principal Sum 3. Paraplegia (total paralysis of Both Lower Limbs): 75% of the Principal Sum 4. Hemiplegia (total paralysis of Upper and Lower Limbs on One Side of the Body): 50% of the Principal Sum 5. Uniplegia (total paralysis of One Limb): 25% of the Principal Sum

Additional Benefits Schedule applicable to Class I **Contributory** (Please refer to the Benefit Rider for details):

Emergency Transportation Benefit	The maximum amount payable will be: 1. \$500 for any one Accident per Covered Person up to a maximum of two (2) Emergency Transportation Benefits payable per calendar year. Time Frame: twenty-four (24) hours of the Accident .
Emergency Treatment Benefit	The maximum amount payable will be: 1. \$300 for any one Accident per Covered Person up to a maximum of two (2) Emergency Treatment Benefits payable per calendar year. Time Frame: twenty-four (24) hours of the Accident .

D. Principal Sum Schedule

Class I:	Contributory:	\$10,000
The Principal Sum for covered Dependents will be a percentage of Your Principal Sum , on the date of Accident , which is determined by multiplying Your Principal Sum by the percentage below.		
<u>Plan Selected</u>	<u>% Spouse/Domestic Partner</u>	<u>% Child(ren)</u>
Spouse/Domestic Partner only:	100%	0%
Dependent Child(ren) only:	0%	100%
Spouse/Domestic Partner and Dependent Child(ren) :	100%	100%
In no event will the amount be greater than Your Principal Sum .		

E. Premium Rate:

Enrollment Required: ☒ Yes ☐ No

Contributory Premium Due Date: Date defined under the **Policyholder's** written procedures as on file and approved by **Us**.

SECTION II – ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE

Covered Person's Effective Date of **Contributory** Insurance:

the Coverage Effective Date shown on page 1 upon completion of the required **Waiting Period**, if any, indicated above.

Enrollment:

An **Eligible Person** may enroll for coverage under the **Policy** by making written or electronic application for coverage on an enrollment form furnished or approved by **Us**. Coverage will not become effective until the **Eligible Person** has enrolled himself or herself and his or her eligible **Dependents** and paid the required premium, if any.

Initial Enrollment: **Eligible Persons** should enroll themselves and their eligible **Dependents** within the number of days defined under the **Policyholder's** written procedures as on file and approved by **Us**.

Change in Family Status: An **Eligible Person** may enroll or **You** may change **Your** coverage if a change in family status occurs, provided written or electronic application to enroll is made within the number of days defined under the **Policyholder's** written procedures as on file and approved by **Us**. A change in family status means any of the following events:

1. marriage or establishment of a Domestic Partnership;
2. divorce or legal separation (including the dissolution of a Domestic Partnership);
3. birth or adoption of a **Dependent Child(ren)**; or
4. death of a **Spouse/Domestic Partner** or **Dependent Child(ren)**.

SECTION III – DEFINITIONS

This section applies to all Hazards, Coverages and Benefits unless otherwise stated.

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.

Air Travel Carrier means any civilian aircraft with a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:

1. medical certificate; and
2. pilot certificate with a proper rating to pilot such aircraft.

Certificate(s) means this Group Personal Accident Insurance Certificate.

Contributory means that **You** are required to pay all or a portion of the premium.

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

Covered Person means any person who has insurance under the terms of the **Policy**. It includes **You**, and **Your Spouse/Domestic Partner** and/or **Dependent Child(ren)** if a **Plan** covering the **Spouse/Domestic Partner** and/or **Dependent Child(ren)** is selected.

Dependent means **Your Spouse/Domestic Partner** and **Dependent Child(ren)**, as defined in this section. The **Dependent** will only be a covered **Dependent** if a **Plan** covering **Dependents** is selected.

Dependent Child(ren) means those unmarried **Child(ren)** of **Yours**, and those unmarried **Child(ren)** of **Your Spouse/Domestic Partner**, including newborn, adopted children, grandchildren and children under guardianship, and those unmarried **Child(ren)** who rely on **You** for their support, and are either: 1) less than twenty-six 26 years of age; 2)

less than thirty (30) years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental incapacity or physical handicap. The **Dependent Child(ren)** will only be covered **Dependent Child(ren)** if a **Plan** covering **Dependent Child(ren)** is selected.

Domestic Partner means a person who qualifies as a **Domestic Partner** under the law of the state of residence. To qualify as a **Domestic Partner**, the following requirements must be met:

1. **You** and **Your Domestic Partner** have been financially interdependent for at least six (6) consecutive months prior to the application in which each individual contributes to some extent to the other individual's maintenance and support with the intention of remaining in the relationship indefinitely;
2. **You** and **Your Domestic Partner** must share a common primary address;
3. **You** and **Your Domestic Partner** must both be at least eighteen (18) years of age;
4. neither **You** nor the **Domestic Partner** are legally married or in a civil union or **Domestic Partnership** with another individual;
5. **You** and **Your Domestic Partner** are not **Related** by blood or marriage within four degrees of consanguinity under the civil law rule.

The existence of the relationship between the **Domestic Partner** and **You** must be evidenced by:

1. A signed affidavit of **Domestic Partnership** on file with **Us**;
2. Proof of common residence; and
3. Proof of financial interdependence.

Any one of the following will be considered satisfactory proof of common residence:

1. Common ownership of the primary residence via joint deed or mortgage agreement;
2. Common leasehold interest in the primary residence;
3. Driver's license or State-issued identification listing a common address; or
4. Utility or other household bill with both the name of the **Insured** and the name of the **Domestic Partner** appearing.

Any one of the following will be considered satisfactory proof of financial interdependence:

1. Joint bank account or credit account;
2. Designation as the primary beneficiary for life insurance or retirement benefits of the **Domestic Partner**;
3. Designation as primary beneficiary under the **Domestic Partner's** will;
4. Mutual assignments of valid durable powers of attorney under Estates and Trusts Article, § 13-601, Annotated Code of Maryland;
5. Mutual valid written advanced directives under Health-General Article, § 5-601 et seq., Annotated Code of Maryland, approving the other **Domestic Partner** as health care agent;
6. Joint ownership or holding of investments; or
7. Joint ownership or lease of a motor vehicle.

For the **Domestic Partner** to be eligible, **You** will not have completed a Termination of Domestic Partner status form with respect to the **Domestic Partner** who is to be covered under the **Policy**.

A **Domestic Partner** will only be a covered **Domestic Partner** if a **Plan** covering **Your Domestic Partner** is selected.

Eligible Person means an individual who:

1. is in an Eligible Class as described in the Classification and Eligibility part of SECTION I - SCHEDULE; and
2. has satisfied the **Waiting Period** as described in the Classification and Eligibility part of SECTION I - SCHEDULE, if any.

Hospital means an institution which:

1. operates pursuant to law;

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 twenty-four (24) hour nursing service by or under the supervision of graduate registered nurses (R.N.).

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

- a. a nursing home, convalescent home, or skilled nursing facility;
- b. a place of rest, custodial care, or for the aged;
- c. a clinic; or
- d. 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 or Hospital Confinement (Hospitalization) means a stay by the **Covered Person** confined to a bed in a **Hospital** for which a room charge is made. However, this exclusion does not apply to treatment received in a **Hospital** or other institution of the State of Maryland or of a county or municipal corporation of the State of Maryland, whether or not the **Hospital** or other institution is deemed charitable, if the **Covered Person** is liable for payment of such treatment or is eligible for or receives medical assistance in accordance with Maryland's laws.

The **Hospital Confinement** must be on the advice of a **Physician**, it must be **Medically Necessary**, and the result of **Injuries** sustained in an **Accident** or for rehabilitative care and treatment for **Injuries** sustained in an **Accident**. **Hospital Confinement** also means the period of **Hospital Confinement** that starts while the **Policy** is in force. If the **Hospital Confinement** follows a previously covered **Hospital Confinement**, it will be deemed a continuation of the first **Hospital Confinement** unless (1) the later **Hospital Confinement** is the result of an entirely unrelated **Injury** or (2) the **Hospital Confinements** are separated by ninety (90) days or more. **Hospitalization** that begins prior to the end of one calendar year and continues into the next calendar year will be considered one **Hospital Confinement**.

Injury means a bodily injury caused directly by an **Accident**, independent of sickness, disease, bodily infirmity, or any other cause.

Insured means a **Member** who is eligible for coverage under the **Policy** as provided in the Classification and Eligibility part of SECTION I - SCHEDULE, and who completes the enrollment material, if required.

Medically Necessary means that the ordering Physician has determined the medical service or treatment:

1. is essential for the diagnosis, treatment or care of the **Injury** for which it is prescribed or performed; and
2. meets generally accepted standards of medical practice.

Member means a person or organization approved as a member of the **Policyholder** under the governing documents (such as the declaration and bylaws) of the **Policyholder**.

Physician means a person who is:

1. a doctor of medicine, osteopathy, or psychology 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 the **Covered Person** by blood or marriage.

Plan means the Hazards, Coverages and/or Benefits as set forth in the Schedule.

Plegia means a paralysis arising from an **Accidental Injury** resulting in a **Covered Loss**.

Policy means the Group Personal Accident Policy issued to the **Policyholder**.

Policyholder means the entity named on the face page of the **Policy**.

Principal Residence means the country of the legal domicile of the **Covered Person**.

Principal Sum means the amount of insurance applicable to the **Covered Person** as stated in the Principal Sum Schedule.

Related means a person who is a **Spouse/Domestic Partner**, an adult living in the same household, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.

Spouse, if used in the **Policy**, means **Your** legally married **Spouse**. A **Spouse** will only be a covered **Spouse** if a **Plan** covering **Your Spouse** is selected.

War or **Act of War** means the hostile contention by means of armed forces, carried on between nations, states, or rulers, or between citizens in the same nation or state.

We, Us, and Our refers to Zurich American Insurance Company.

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

SECTION IV – HAZARDS

Subject to all the terms, conditions, limitations, and exclusions set forth in the **Policy**, the Hazards are also subject to the following additional terms, conditions, limitations, and exclusions.

The Hazards insured against by the **Policy** are:

H-1 24 Hour Accident Protection Coverage

An **Injury** sustained by a **Covered Person** resulting in a **Covered Loss** anywhere in the world.

Additional Hazard Limitations:

For purposes of this hazard only, the following additional limitation applies:

Coverage for air travel is limited to a **Covered Loss** sustained by **Covered Person** as a passenger, during a trip while riding in or on, boarding, or alighting from:

1. an **Air Travel Carrier**; or
2. any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of American or the Armed Forces of any foreign government.

SECTION V – COVERAGES

Coverages afforded and Benefits payable are based on the Hazards insured against as set forth in SECTION I - SCHEDULE.

C – 1 Accident Medical Expense Coverage:

Accident Medical Expense Benefit

Accident Medical Expense Schedule		
Benefit	Maximum Benefit per Covered Person per Accident	Deductible per Covered Person per Accident
Accident Medical	as set forth in the Section I - Schedule	as set forth in the Section I - Schedule

We will pay the **Usual and Customary** expenses for **Medically Necessary Covered Medical Service(s)** incurred by the **Covered Person** due to an **Injury** resulting from an **Accident**, up to the Maximum Benefit set forth in the Accident Medical Expense Schedule. Coverage is provided in excess of the deductible(s) set forth in the Accident Medical Expense Schedule provided that:

1. the first treatment or service occurs within ninety (90) days of the **Injury**; and
2. the medical expenses are incurred within fifty-two (52) weeks of the **Injury**.

For purposes of this benefit only, the following additional definitions apply:

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

1. **Hospital** room and board expenses: the daily room rate when a **Covered Person** 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 **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 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;
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 an **Injury** requires multiple surgical procedures through the same incision, **We** will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session but through different incisions, **We** will pay for the most expensive procedure;
8. licensed Physician Assistant services;
9. the services of a registered nurse;
10. anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis;
11. outpatient laboratory test expenses;
12. physiotherapy expenses on an inpatient or outpatient basis limited to one (1) visit per day to a maximum of four (4) 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;
13. x-ray expenses (including reading charges) but not for dental X-rays unless **Medically Necessary** to evaluate an **Injury**;
14. radiological procedures;
15. diagnostic imaging expenses including Magnetic Resonance Imaging (MRI) and Computed Axial Tomography (CAT) Scan;
16. ambulance expenses for transportation from the emergency site to the **Hospital**;
17. rehabilitative braces or appliances prescribed by a **Physician**. 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.
18. prescription drug prescribed by a **Physician**, for **Injuries**;
19. medical equipment rental expenses for a wheelchair or other medical equipment that has therapeutic value for a **Covered Person**. **We** will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs, eyeglasses and hearing aids. **We** will, however, cover hearing aid expenses for a minor Dependent Child who is covered under the Policy if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist. **We** will pay up to a maximum of \$1,400 per hearing aid for each hearing-impaired ear every 36 months for a **Dependent Child** covered under this **Certificate**;
20. expenses for blood and blood transfusions; oxygen and its administration;
21. An objective second opinion given to the **Covered Person** when required by a utilization review program required under Maryland law.

22. **Home Health Care** provided by a **Hospital** or licensed public or private home health agency for up to forty (40) home health care visits in a continuous twelve (12) month period for each **Covered Person**. Each visit by a member of a home health care team is considered one (1) home health care visit and up to four (4) hours of home health care service is considered as one (1) home health care visit.
23. Patient Costs for the **Covered Person** participating in a clinical trial as a result of treatment provided for a life-threatening **Injury** due to a **Covered Accident**. Treatment must be provided in a Phase 1, Phase II, Phase III, or Phase IV clinical trial. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise. There is no clearly superior, noninvestigational treatment alternative. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative. The treatment is being provided in a clinical trial approved by:
- one of the National Institutes of Health;
 - an NIH Cooperative Group or an NIH center;
 - the FDA in the form of an investigational new drug application;
 - the federal Department of Veterans Affairs; or
 - an institutional review board of an institution in the State of Maryland which has a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the National Institutes of Health.

In conjunction with the above, patient costs incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the **Covered Person's** particular **Injury**, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

24. The administration of general anesthesia and associated **Hospital** or ambulatory facility charges in conjunction with dental care required due to a **Covered Accident** provided to the **Covered Person** if he or she
- is seven (7) years of age or younger or is developmentally disabled; is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition; or is an individual for whom a superior result can be expected from dental care provided under general anesthesia;
 - is an extremely uncooperative, fearful, or uncommunicative child who is seventeen (17) years of age or younger with dental needs of such magnitude that treatment should not be delayed or deferred; and is an individual for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

Coverage for general anesthesia and associated **Hospital** or ambulatory facility charges is restricted to dental care that is provided by:

- a fully accredited specialist in pediatric dentistry;
- a fully accredited specialist in oral and maxillofacial surgery; and
- a dentist to whom Hospital privileges have been granted.

This benefit does not cover dental care rendered for temporomandibular joint disorders.

Custodial Services means non-medical care, including, but not limited to, services:

- related to watching or protecting the **Covered Person**;
- related to performing, or assisting the **Covered Person** 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 usually be self-administered;
- that are not required to be performed by trained or skilled medical personnel;
- that are prescribed by a **Physician**; and
- that are provided by persons not **Related** to the **Covered Person**.

Hearing Aid means a device that:

1. is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children; and
2. is nondisposable.

Home Health Care means the continued care and treatment of the injured **Covered Person** if:

1. such person would have to be institutionalized if home health care was not available; and
2. such person's Physician establishes and approves in writing the plan of treatment covering the home health care service.

Medical Repatriation means transporting a **Covered Person** back to his or her **Principal Residence** or to the country where he or she was assigned due to the **Covered Person** being injured.

Sound Natural Teeth means natural teeth that are unaltered or are fully restored to their normal function and are disease free, have no decay, and are not more susceptible to injury than unaltered natural teeth.

Usual and Customary 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** rate approved by the Maryland Health Services Cost Review Commission for Hospitals located in Maryland; 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. For **Hospitals** in Maryland, **Usual and Customary** Expense(s) means the rate approved by the Health Services Cost Review Commission. **We** will only pay up to 50% of a non-generic drug if a generic drug is available.

COVERAGE OF DEPENDENT CHILD(REN) BENEFIT

Your Dependent Child(ren) may be added to the coverage under this Benefit at any time and without evidence of insurability provided:

1. the **Dependent Child(ren)** were previously covered under the policy or contract of **Your Spouse/Domestic Partner**; and
2. **Your Spouse/Domestic Partner** has died; or
3. **You** are ordered by a court of this state or another state or an administrative agency of another state, to provide health insurance coverage for a **Child**.

If **You** are eligible for family member coverage and required under an order to provide health insurance coverage for a child **You** shall be allowed to enroll in family members' coverage and include the child(ren) regardless of enrollment period restrictions. If **You** do not include the child in the enrollment the non-insuring parent, child support enforcement agency, or Department of Health and Mental Hygiene may apply for enrollment on behalf of the child irrespective of enrollment period restrictions. **We** may not terminate coverage under this Benefit for the child unless written evidence is provided that:

- a. the order is no longer in effect;
- b. the child has been or will be enrolled under other reasonable coverage that will take effect on or before the effective date of the termination;
- c. the employer has eliminated family member's coverage for all its employees; or
- d. the employer no longer employs **You**, except that if **You** elect to exercise the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Notwithstanding any other provisions, no child will be denied coverage under **Your Policy** because the child was born out of wedlock, is not claimed as a dependent on **Your** federal income tax return; does not reside with **You** as long as the child resides within the Coverage Territory; or is receiving benefits or is eligible to receive benefits under the Maryland Medical Assistance Program.

If a child has health insurance coverage through the **Insured**, **We** will:

- i. provide to the non-insuring parent membership cards, claims forms and any other information necessary for the child to obtain benefits through the **Policy**; and

- ii. process the claims forms and make appropriate payment to the non-insuring parent, health care provider, or Department of Health and Mental Hygiene if the noninsuring parent incurs expenses for health care provided to the child.

You must exercise this benefit within six (6) months after the death of **Your Spouse/Domestic Partner**.

Third Party in the singular or plural means, but is not limited to, the following:

1. the party that caused the **Covered Accident, Covered Injury** or other medical condition and any insurer or indemnifier thereof; or
2. any other person, entity, policy or plan that is liable or legally responsible to make payments in relation to the **Covered Accident, Covered Injury** or other medical condition.

Total Disability/Totally Disabled means, during the first 12 months of such disability, inability by reason of **Covered Injury** to perform each and every duty pertaining to **Your** occupation. After the first 12 months of such disability, **Total Disability/Totally Disabled** means inability to perform each and every duty of any business or occupation for which **You** are reasonably fitted by education, training and experience.

Exclusions:

For purposes of this benefit only, the following additional exclusions apply:

We will not cover the following:

1. cosmetic, plastic or restorative surgery unless **Medically Necessary** for the treatment of the **Injury**;
2. any medical expenses related to pregnancy unless **Medically Necessary** for the treatment of the **Injury**;
3. **Injury** for which the **Covered Person** is entitled to benefits under Workers Compensation Benefits, Employer Liability Law, or other similar law;
4. travel outside of the United States of America;
5. personal comfort or convenience items, such as but not limited to **Hospital** telephone charges, television rental, or guest meals;
6. treatment by any person **Related** to the **Covered Person**;
7. expenses incurred for dental care, treatment, repair or replacement of **Sound Natural Teeth** unless **Medically Necessary** for the treatment of the **Injury**;
8. expenses incurred for eye examinations, eye glasses, contact lenses or hearing aids or the fitting, repair or replacement of these items unless **Medically Necessary** for the treatment of the **Injury**;
9. routine physical examinations and related medical services, or elective treatment or surgery, or experimental or investigative treatments or procedures. However, these services will be covered if the attending **Physician** determined they are **Medically Necessary**;
10. a **Medical Repatriation**;
11. expenses incurred for psychological or psychiatric counseling of any kind or any expense for treatment of mental or nervous diseases or disorders;
12. expenses which the **Covered Person** is not legally obligated to pay, except Medicaid;
13. expenses for **Custodial Services** or services provided by a private duty nurse unless such expenses are incurred as a result of an **Injury**;
14. 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 **Injury** has caused further impairment in the underlying bodily condition;
15. treatment involving conditions caused by repetitive motion injuries or cumulative trauma and not a result of an **Injury**;
16. treatment of Osgood-Schlatter's Disease.

EXTENSION OF BENEFITS

Except in the case of nonpayment of premium or fraud by the **Covered Person** and for dental care due to a **Covered Injury**, a **Covered Person** is **Totally Disabled** as a result of a **Covered Injury** on the date that coverage under this Benefit would otherwise terminate, benefits under this Accident Medical Expense Benefit for the condition causing the **Total Disability** will continue to be payable until the earliest of the following:

1. the date the **Covered Person** is no longer **Totally Disabled**;
2. the date the Maximum Benefit is reached; or
3. 12 months after the date coverage under this Benefit would have terminated.

We may require proof of **Total Disability**.

With regard to dental care that is **Medically Necessary** due to a **Covered Accident**, benefits for such dental care will continue for ninety (90) days if the treatment first began and **Covered Services** were provided before coverage would otherwise terminate and which requires two (2) or more visits on separate days to a dentist's office.

Subrogation

If a **Third Party** is found liable for a **Covered Loss**, **We** have the right to recover from such **Third Party** all payments including future payments, which **We** have made or will make in the future to the **Covered Person** or his or her heirs, guardians or executors or will be obligated to pay in the future to the **Covered Person**. If the **Covered Person** recovers from any **Third Party**, **We** will be reimbursed first from such recovery to the extent of **Our** payments to or on behalf of the **Covered Person** reduced by a pro rata share of any court costs and legal fees incurred by the **Covered Person** which are applicable to the portion of the settlement returned to **Us**. The **Covered Person** agrees to assist **Us** in preserving his or her rights against any **Third Party**, including but not limited to, signing subrogation forms supplied by **Us**.

This benefit is subject to the limitations in SECTION VII - GENERAL LIMITATIONS.

C – 3 Accidental Death/Catastrophic Injury Coverage:

Accidental Death Benefit

If a **Covered Person** suffers an **Injury** resulting in a loss of life, **We** will pay the applicable **Principal Sum** as set forth in the Schedule. The death must occur within 365 days of the **Injury**.

Accidental Dismemberment and Plegia Benefit

If a **Covered Person** suffers an **Injury** resulting in any of the following **Covered Losses**, **We** will pay the benefit amount set forth in the Schedule. The **Covered Loss** must occur within 365 days of the **Accident**.

The benefit amounts are based on the **Principal Sum** of the person suffering the **Covered Loss**.

A reduced benefit will be payable equal to 10% of the applicable Accidental Dismemberment Benefit for dismemberment where the dismembered body part is surgically reattached, provided all other provisions of the **Policy** are met. The balance of the applicable Accidental Dismemberment Benefit for such dismemberment will be paid if, after 365 day(s), the reattachment has failed to the extent that **Covered Loss of Use** then exists, provided all other provisions of the **Policy** are met.

For purposes of this benefit only:

Covered Loss means:

- a. For a Foot or Hand, actual severance through or above an Ankle or Wrist Joint;
- b. Actual severance through or above the Metacarpophalangeal Joint of a Thumb and Index Finger;
- c. Total and permanent loss of Sight;
- d. Total and permanent loss of Speech;
- e. Total and permanent loss of Hearing.

Plegia means permanent, functional and irreversible paralysis of one (1) or more **Limbs** as determined by a **Physician** and which must continue for twelve (12) consecutive months.

Limb means an Arm or a Leg.

Proof of total or functional paralysis may be required by **Us** on a periodic basis. Benefits are not payable for paralysis caused by a stroke.

EXTENSION OF BENEFITS

Except in the case of nonpayment of premium, fraud or coverage provided by a succeeding health plan that is provided at a cost to the **Covered Person** that is less than or equal to the cost to the **Covered Person** of the extended benefit and does not result in an interruption of benefits; **We** will provide coverage under this Benefit for a loss that occurs after the date coverage terminated if:

1. an accident occurs while the **Covered Person** is covered; and
2. the **Covered Loss** occurs within 90 days after the accident.

This benefit is subject to the limitations in SECTION VII - GENERAL LIMITATIONS.

SECTION VI – GENERAL EXCLUSIONS

This section applies to all Hazards, Coverages and Benefits unless otherwise stated.

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, including Reserve or National Guard active duty which extends beyond thirty-one (31) consecutive days. This exclusion does not apply to the first thirty-one (31) consecutive days 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; except for **Accidental** ingestion of contaminated foods;
5. the **Insured's** commission or attempted commission of any felony (this applies to Disability and Accidental Death and Dismemberment Benefits only);
6. parasailing, bungee jumping, heli-skiing, or scuba diving;
7. loss sustained or contracted in consequence of the **Insured** being under the influence of any narcotic unless prescribed by a **Physician** and taken in accordance with the prescribed dosage (this applies to Disability and Accidental Death and Dismemberment Benefits only);
8. a cardiovascular event or stroke caused by exertion prior to or at the same time as an **Accident**;

SECTION VII – GENERAL LIMITATIONS

This section applies to all Hazards, Coverages and Benefits unless otherwise stated.

Limitation on Multiple Covered Losses. If a **Covered Person** suffers more than one **Covered Loss** as a result of the same **Accident**, **We** will pay only one benefit, the largest benefit.

Limitation on Multiple Coverages and Benefits. If a **Covered Person** suffers a **Covered Loss** which is payable under more than one benefit as a result of the same **Accident**, the most **We** will pay for these benefits in total is the **Covered Person's Principal Sum**.

Limitation on Multiple Hazards. If a **Covered Person** suffers a **Covered Loss** under more than one Hazard, **We** will pay only one benefit, the largest benefit.

SECTION VIII - TERMINATION OF INSURANCE

A. Termination of **Covered Person's** Insurance

You. Insurance automatically terminates on the earliest of:

1. the date the **Policy** is terminated;

2. the date **You** cease to be eligible for insurance;
3. the expiration date of the period for which required premium has been paid for by **You**;
4. the date **You** fail to pay the required premium, if **You** are so required; or
5. the date **You** reach age seventy (70).

Covered Person other than **You**. Insurance terminates on the earliest of:

1. the date the insurance for **You** terminates;
2. the first premium due date after the person no longer qualifies as a **Covered Person**; or
3. for the covered **Spouse/Domestic Partner**, the date the covered **Spouse/Domestic Partner** reaches age seventy (70).

Extension of Benefits. Except in the case of nonpayment of premium or fraud by a **Covered Person**, termination of a **Covered Person's** coverage will not prejudice a benefit that would otherwise be payable provided the **Accident** occurred while coverage was in force and the **Covered Loss** occurs within 90 days of that **Accident**.

Continuation of Coverage for Change in Status

The **Insured** may continue coverage if the **Insured** experiences a change in status which includes: 1) Involuntary termination of the **Insured's** employment other than for cause; and 2) Voluntary termination of the **Insured's** employment by the **Insured** employee. If the **Insured** elects to continue coverage due to a change in status, the **Policy** shall begin on the date of the change in status and end on the earliest of the following:

1. 18 months after the change in status;
2. the date the **Insured** fails to make timely payment as required in continuation of coverage based on a change of status number 2 below;
3. the date on which the **Insured** becomes eligible for hospital, medical, or surgical benefits under an insured or self-insured group health benefit program or plan, other than a group contract, that is written on an expense-incurred basis or is with a health maintenance organization;
4. the date the **Insured** becomes entitled to benefits under Title XVIII of the Social Security Act;
5. the date on which the **Insured** accepts hospital, medical, surgical coverage under a non-group contract of policy that is written on an expense-incurred basis or is with a health maintenance organization;
6. the date in which the **Insured** elects to terminate coverage under the group contract; or
7. the date on which the employer ceases to provide benefits to its employees under a group contract.

Continuation of coverage based on a change of status shall:

1. be provided without evidence of insurability or additional waiting periods;
2. require the **Insured** to pay to the employer an amount that does not exceed:
 - a. the sum of the employer contribution and any contribution that the **Insured** would have been required to pay if there had not been a change in status; and
 - b. a reasonable administrative fee that is subject to review and approval by the Commissioner.
3. allow the payment of the amount specified in item 2 of this sub-section in monthly installments if the **Insured** elects to do so;
4. be identical to the coverage offered under this **Policy** to similarly situated individuals for whom there has not been a change in status;
5. be available to the **Spouse** and **Dependent Children** of the **Insured** if the **Insured's Spouse** and **Dependent Children** were covered under the **Policy** before the change in status.

For continuation of coverage under this section, an **Insured** or authorized representative shall submit a signed notification form to the **Insured's** employer. Within fourteen (14) days after receipt of a request for a notification form, the employer shall deliver or send by first class mail the notification form to the **Insured** or authorized representative.

We will issue a certificate to the **Insured** which shall include a statement that advises: 1) the availability of continuation coverage under this section; 2) a summary of the eligibility for and duration of the continuation coverage and the procedure for requesting to receive continuation coverage if a change of status occurs.

We shall provide continuous open enrollment for the purposes of allowing a married **Insured** who is enrolled under this **Policy** to alter the terms of the **Insured's** coverage to include the **Insured's Spouse** or **Dependent Children** if the **Insured's Spouse** loses coverage under another Accident policy because of the involuntary termination of the **Spouses** employment other than for cause. We will not require evidence of insurability for a **Spouse** who qualifies for coverage under this section. The **Insured** who wishes to alter the terms of their coverage shall notify the employer within six (6) months after the date on which the coverage of the **Insured's Spouses** policy terminates.

Continuation of Coverage For Death of **Insured**

If this **Policy** is in force on the date of death of the **Insured**, we shall provide continuation coverage to a qualified secondary beneficiary. A qualified secondary beneficiary is 1) the **Spouse** of the **Insured** at least 30 days immediately preceding the death of the **Insured**; and 2) **Dependent Child(ren)**, which includes a child who was covered under this **Policy** prior to the death of the **Insured**; or who is a child of the **Insured's** but was born to the surviving **Spouse** after the **Insured's** death. For continuation of coverage, coverage shall begin on the date of death of the **Insured** and end on the earliest of:

1. 18 months after the death of the **Insured**;
2. the date the qualified secondary beneficiary fails to make timely payment as required in continuation of coverage number 2 below;
3. the date on which the qualified secondary beneficiary becomes eligible for hospital, medical, or surgical benefits under an insured or self-insured group health benefit program or plan, other than a group contract, that is written on an expense-incurred basis or is with a health maintenance organization;
4. the date the qualified secondary beneficiary becomes entitled to benefits under Title XVIII of the Social Security Act;
5. the date on which the qualified secondary beneficiary accepts hospital, medical, surgical coverage under a non-group contract of policy that is written on an expense-incurred basis or is with a health maintenance organization;
6. the date in which the qualified secondary beneficiary elects to terminate coverage under the group contract;
7. the date on which the employer ceases to provide benefits to its employees under a group contract; or
8. for an individual who is a qualified secondary beneficiary by reason of having been a **Dependent Child**, the date on which the individual would no longer be covered under this **Policy** had the **Insured** not died.

Continuation of coverage shall:

1. be provided without evidence of insurability or additional waiting periods;
2. require the qualified secondary beneficiary to pay to the employer an amount that does not exceed:
 - a. the sum of the employer contribution and any contribution that the **Insured** would have been required to pay if there had not been a change in status; and
 - b. a reasonable administrative fee that is subject to review and approval by the Commissioner.
3. allow the payment of the amount specified in item 2 of this sub-section in monthly installments if the qualified secondary beneficiary elects to do so;
4. be identical to the coverage offered under this **Policy** to similarly situated individuals for whom there has not been a change in status.

For continuation of coverage under this section, a qualified secondary beneficiary or authorized representative shall submit a signed notification form to the **Insured's** employer. Within fourteen (14) days after receipt of a request for a notification form, the employer shall deliver or send by first class mail the notification form to the **Insured** or authorized representative.

We will issue a certificate to the qualified secondary beneficiary which shall include a statement that advises: 1) the availability of continuation coverage under this section; 2) a summary of the eligibility for and duration of the continuation coverage and the procedure for making an election to receive continuation coverage if a change of status occurs.

Continuation of Coverage – Divorced Spouses

A qualified secondary beneficiary may continue coverage if the **Insured** experiences a change in status. Change in status means the divorce of the **Insured** and the **Insured's Spouse**. For purposes of this section, a qualified secondary beneficiary

is: 1) the **Spouse** of the **Insured** at least 30 days immediately preceding the change in status; and 2) **Dependent Child(ren)**, which includes a child who was covered under this **Policy** immediately preceding the change in status or who is a child of the **Insured's** but was born to the **Spouse** after the change in status. If the qualified secondary beneficiary continues coverage due to a change in status, the **Policy** shall begin on the date of the change in status and end on the earliest of the following:

1. the date on which the qualified secondary beneficiary becomes eligible for hospital, medical, or surgical benefits under an insured or self-insured group health benefit program or plan, other than a group contract, that is written on an expense-incurred basis or is with a health maintenance organization;
2. the date the qualified secondary beneficiary becomes entitled to benefits under Title XVIII of the Social Security Act;
3. the date on which the qualified secondary beneficiary accepts hospital, medical, surgical coverage under a non-group contract or policy that is written on an expense-incurred basis or is with a health maintenance organization;
4. the date in which the qualified secondary beneficiary elects to terminate coverage under the group contract;
5. for an individual who is a qualified secondary beneficiary by reason of having been a **Dependent Child**, the date on which the individual would no longer be covered under this **Policy** if there had not been a change in status;
6. for an individual who is a qualified secondary beneficiary by reason of having been the **Insured's Spouse**, the date on which the individual remarries.

Continuation of coverage shall be identical to the coverage offered under this **Policy** to similarly situated individuals for whom there has not been a change in status.

From the date of the change in status until the date on which a **Termination Statement** is received by the employer, the **Insured** shall pay the employer, through payroll deduction or as otherwise determined by the employer the sum of the employer's contribution for a qualified secondary beneficiary the amount of the contribution that would have been paid by the **Insured** if there had not been a change in status. The additional costs payable by the **Insured** may be allocated between the **Insured** and the qualified secondary beneficiary who was the **Insured's Spouse** or may be reimbursed in full to the **Insured** by the qualified secondary beneficiary by agreement between the parties, or as equity may require, by court order under the Family Law Article of Maryland.

We will issue a certificate to the qualified secondary beneficiary once the qualified beneficiary or authorized representative notify the **Insured's** employer regarding the change in status.

For purposes of Section D Continuation of Coverage – Divorced Spouses, the following definition applies:

Termination Statement means written notice of an event specified above in this section:

1. provided to the employer on a form that the Commissioner prescribes; and
2. signed by the **Insured** and a qualified secondary beneficiary or accompanied by the **Insured's** signed and sworn affidavit that verifies all facts in the termination statement.

Continuation of Coverage – Death of Spouse

This **Policy** provides a benefit for the addition of an **Insured's Dependent Child(ren)** at any time and without evidence of insurability if:

1. the **Dependent Child(ren)** previously were covered under the policy of the **Insured's Spouse**; and
2. the **Insured's Spouse** has died.

From the date of the death of the **Spouse** until the date on which a **Termination Statement** is received by the employer, the **Insured** shall pay the employer, through payroll deduction or as otherwise determined by the employer the sum of the employer's contribution for the **Dependent Children**.

Within 6 months after the death of the **Spouse**, the **Insured** must exercise the benefit provided under this section.

SECTION IX - HOW TO FILE A CLAIM

- A. Notice. **You** or the beneficiary, or someone on their behalf, must give **Us** written notice of the **Covered Loss** within ninety (90) days of such **Covered Loss**. Failure to provide notice within the required time will not invalidate or reduce a claim if it was not reasonably possible to provide notice in such time, and notice was provided as soon thereafter as reasonably possible. The written notice of claim is not required before twenty (20) days after the occurrence or commencement of the loss. The notice must name the **Covered Person** who sustained the **Injury, You**, and the Policy Number. To request a claim form, **You** or the beneficiary, or someone on their behalf may contact **Us** at

Administrative Concepts, Inc.
P.O. Box 4000
Collegeville, PA 19426
(800) 410-9153
EDI Payor ID: 22384

The notice must be sent to the Claims Department, Zurich American Insurance Company, Administrative Concepts, Inc., 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 **We** receive notice, the claimant is considered to have complied with the requirement of the Policy as to Proof of Loss if the claimant submits, within the time fixed in the Policy for filing Proof of Loss, written proof of the occurrence, character, and extent of the loss for which the claim is made.
- C. Proof of Loss. Written Proof of Loss must be sent to **Us** within ninety (90) days of the **Covered Loss** or within 90 days after the commencement of the period for which the carrier is liable, and the subsequent written proofs that the disability continues shall be furnished to the carrier at the intervals that the carrier reasonably requires. Failure to furnish Proof of Loss within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the proof within the required time, if the proof is furnished as soon as reasonably possible and, except in the absence of legal capacity of the claimant, not later than one (1) year from the time proof is otherwise required.

SECTION X - 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, within thirty (30) days of receipt of written Proof of Loss. 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**.
- B. Who We Will Pay.
1. Loss of Life of **You**. **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 the **Insured's** named contingent beneficiary. If there is no beneficiary or contingent beneficiary named by **You** for the **Policyholder's** Group Life Insurance policy, or the named beneficiary or contingent beneficiary predeceases or dies at the same time as **You**, **We** will pay the benefit to **Your** survivors in the following order:
 - a. **Your** legally married **Spouse/Domestic Partner**;
 - b. **Your Dependent Child(ren)**;
 - c. **Your** parents;
 - d. **Your** brothers and sisters;
 - e. **Your** estate.
 2. Loss of Life of a **Covered Person** other than **You**. **Covered Losses** for the death of a **Covered Person** other than **You** will be paid to **You**. If **You** pre-decease or die at the same time as the **Covered Person** other than **You**, the

benefit will be paid to the beneficiary unless the beneficiary designation has not been made or the beneficiary is no longer living at the time of death. In such case, the benefits will be paid to **Your** estate.

3. All Other Claims. Benefits are to be paid to the **Covered Person**.
- C. Physical Examination and Autopsy. **We** have the right to examine a **Covered Person** when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** can, at **Our** expense, have an autopsy performed unless forbidden by law.
- D. Choice of Service Provider. The **Covered Person** has the sole right to choose his or her **Physician** and **Hospital**.
- E. Prohibited Referral. We will not make payment of any claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral.

SECTION XI - GENERAL POLICY CONDITIONS

This section applies to all Hazards, Coverages and Benefits unless otherwise stated.

- 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. **You** may change the beneficiary at any time unless **You** have 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 unless the previous beneficiary was designated as irrevocable. Any beneficiary designation must be submitted to **Us** in writing.
- 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** officers. No such change is valid unless endorsed on this **Policy** or attached to this **Policy**. 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 of the date the written proof of **Covered Loss** was required to be submitted. If the law of the state where the **Covered Person** lives makes such limit void, then the action must begin within the shortest time period permitted by law.
- E. Contestability of Coverage. In the absence of fraud, statements made by the **Policyholder** or a **Covered Person** 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, a copy of which is provided to the **Policyholder** or a **Covered Person**. A statement made by any person covered under the policy relating to insurability may not be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force before the contest for a period of 2 years during the person's lifetime. This **Policy** may not be contested, except for nonpayment of premiums, after it has been in force for two (2) years from its date of issue.
- F. Arbitration. Any contest to a claim denial under the **Policy** may be settled by binding arbitration at the **Covered Person's** option. Arbitration will be administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration will occur at the offices of the American Arbitration Association nearest to the **Covered Person**. The arbitrator(s) will not award consequential or punitive damages in any arbitration under this section. This provision does not apply if the **Covered Person** is a resident of a state where the law does not allow binding arbitration in an insurance policy, but only if the **Policy** is subject to its laws. In such a case, binding arbitration does not apply. Agreement to binding arbitration bars the institution of lawsuit by the **Covered Person**.

Emergency Transportation 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 Group Personal Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made in the **Policy/Certificate** to which this rider is attached:

If a **Covered Person** must be transported to a **Hospital** or a **Satellite Emergency Center** by **Ambulance**, as a result of an **Injury** that requires **Medically Necessary Emergency Treatment**, **We** will pay an additional benefit if such transport occurred within the Time Frame set forth in the Additional Benefits Schedule. Only one Emergency Transportation Benefit is payable per **Accident** per **Covered Person**. The maximum number of Emergency Transportation Benefits payable per calendar year per **Covered Person** regardless of the number of **Accidents** is set forth in the Additional Benefits Schedule.

EXTENSION OF BENEFITS

Except in the case of nonpayment of premium, or coverage provided by a succeeding health plan that is provided at a cost to the **Covered Person** that is less than or equal to the cost to the **Covered Person** of the extended benefit and does not result in an interruption of benefits, if a **Covered Person** is **Disabled** as a result of a **Covered Injury** on the date that coverage under this Rider would otherwise terminate, benefits under this Rider for the condition causing the **Disability** will continue to be payable until the earliest of the following:

1. the date a **Covered Person** is no longer **Totally Disabled**;
2. the date the Maximum Benefit is reached; or
3. twelve (12) months after the date coverage under this Rider would have terminated.

We may require proof of **Total Disability**.

Additionally, if the **Covered Person** is confined in a **Hospital** on the date coverage terminates, benefits under this Rider for the **Covered Injury** causing the confinement will continue to be payable until the earliest of the following:

1. the date the **Covered Person** is discharged from the **Hospital**;
2. twelve (12) months after the date coverage terminated; or
3. the date the Maximum Benefit is reached.

SECOND OPINION

We will provide coverage for an objective second opinion given to the **Covered Person** when required by a utilization review program under § 19-319 of the Health — General Article.

For purposes of this rider only, the following additional definitions apply:

Ambulance means any publicly or privately owned surface, water or air vehicle, including a helicopter, that is specifically designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded. **Ambulance** does not include a surface, water or air vehicle that is owned and operated to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport.

Emergency Treatment means treatment provided in an emergency room of a **Hospital** for:

1. a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with average knowledge of health and medicine could reasonably expect the

absence of immediate medical attention to result in placing the health of the person (or with respect to a pregnant woman, the health of her unborn child) in serious jeopardy;

2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

Satellite Emergency Center means a licensed facility that provides outpatient care under the direction of a **Physician** on a twenty-four (24) hour basis. Available services must include:

1. diagnostic care, including laboratory services and diagnostic x-rays; and
2. treatment or medical care, including availability of the means for stabilization of emergency medical conditions.

A **Satellite Emergency Center** does not include a **Hospital** or an office maintained by a **Physician** for the practice of medicine or dentistry.

This benefit is not subject to the limitations in SECTION VII - 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: September 1, 2025 Attached to and forming a part of **Policy** No. GPA 8837399

Signed for by Zurich American Insurance Company:



September 1, 2025

President

Date

Emergency Treatment 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 Group Personal Accident Policy/Certificate.

It is hereby understood and agreed that the following changes are made in the **Policy/Certificate** to which this rider is attached:

If a **Covered Person** requires **Medically Necessary Emergency Treatment** as a result of an **Injury**, **We** will pay an additional benefit if such **Medically Necessary Emergency Treatment** was received within the Time Frame set forth in the Additional Benefits Schedule. Only one Emergency Treatment Benefit is payable per **Accident**, per **Covered Person**. The maximum number of Emergency Treatment Benefits payable per calendar year per **Covered Person** regardless of the number of **Accidents** is set forth in the Additional Benefits Schedule.

EXTENSION OF BENEFITS

Except in the case of nonpayment of premium, or coverage provided by a succeeding health plan that is provided at a cost to the **Covered Person** that is less than or equal to the cost to the **Covered Person** of the extended benefit and does not result in an interruption of benefits, if a **Covered Person** is **Disabled** as a result of a **Covered Injury** on the date that coverage under this Rider would otherwise terminate, benefits under this Rider for the condition causing the **Disability** will continue to be payable until the earliest of the following:

1. the date a **Covered Person** is no longer **Totally Disabled**;
2. the date the Maximum Benefit is reached; or
3. twelve (12) months after the date coverage under this Rider would have terminated.

We may require proof of **Total Disability**.

Additionally, if the **Covered Person** is confined in a **Hospital** on the date coverage terminates, benefits under this Rider for the **Covered Injury** causing the confinement will continue to be payable until the earliest of the following:

1. the date the **Covered Person** is discharged from the **Hospital**;
2. twelve (12) months after the date coverage terminated; or
3. the date the Maximum Benefit is reached.

SECOND OPINION

We will provide coverage for an objective second opinion given to the **Covered Person** when required by a utilization review program under § 19-319 of the Health — General Article.

For purposes of this rider only, the following additional definition applies:

Emergency Treatment means treatment provided in an emergency room of a **Hospital** for:

1. a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the person (or with respect to a pregnant woman, the health of her unborn child) in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

This benefit is not subject to the limitations in SECTION VII - 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: September 1, 2025 Attached to and forming a part of **Policy** No. GPA 8837399

Signed for by Zurich American Insurance Company:

Sierra Squarrelli

September 1, 2025

President

Date

SANCTIONS EXCLUSION ENDORSEMENT



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 cover, payment, service, benefit, or any business or activity of the insured would violate applicable trade or economic sanctions listed by the Office of Foreign Assets Control of (OFAC) of the US Department of Treasury. OFAC maintains a list of Specially Designated Nationals and Blocked Persons.

If an insured or claimant appears on the list or otherwise is determined to have violated a sanction imposed by U.S. law, the policy will be considered blocked; and

If the policy is blocked, we will not pay any benefits or refund premiums without authorization from OFAC.

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

Signed for Zurich American Insurance Company by: _____

A handwritten signature in black ink that reads 'Sierra Signarelli'.

President

Date: 09/01/2025

Privacy Notice

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

Dear Customer:

rev. January 2020

We care about your privacy. That is why we believe in your right to know what nonpublic personal information (“NPI”) we collect about you and what we do with that information. This Privacy Notice describes the NPI we collect about you and how we share and protect that information.

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 NPI. 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 NPI. You are receiving this Privacy Notice because our records show either that you are a customer who is obtaining or has obtained insurance coverage or non-insurance products or services.
What types of Information do we collect?	The types of NPI we collect depend on the product or service you have with us. This information can include: • Information about you we receive on applications or other forms, such as your name, address, telephone number, date of birth, your social security number, driver's license number, employment information, information about your income, assets and net worth, and medical information; • Information about your transactions with the Company and its affiliates; • Information about your insurance coverage, premiums, claims history, and payment history; • Data from insurance support organizations, government agencies, insurance information sharing bureaus; • Property information and similar data about you or your property, such as property appraisal reports; and • Information we receive from a consumer reporting agency or insurance information sharing bureau, such as a credit or fraud 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 NPI we collect?	We share your NPI 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 NPI with affiliated parties and nonaffiliated third parties, as applicable, in the course of supporting your insurance coverage or non-insurance products. These affiliates and nonaffiliated third parties include: • Financial service providers, such as banks and other insurance companies; • Non-financial companies, such as medical providers and nonaffiliated service providers that perform marketing services on our behalf; and • Others, such as consumer reporting agencies and insurance information sharing bureaus. In the section below, we list the reasons we can share your NPI, whether we actually share your NPI, 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 can 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 – such as to process your transactions, administer insurance coverage, products or services, maintain your account, prevent fraud and report to credit bureaus	Yes	No
For our marketing purposes - to offer our products and services to you	Yes	No
For joint marketing with other financial companies	No	Not Applicable
For our affiliates' everyday business purposes – transaction and experience information	Yes	No
For our affiliates' everyday business purposes – information about your creditworthiness	No	Not Applicable
For our affiliates to market to you	Yes	No
For non-affiliates to market their products to you	No	Not Applicable

Collecting and safeguarding information	
How often do you notify me about your privacy 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. Please review the privacy policy posted on our website, ZurichNA.com. It contains additional information about our practices.
Why do you collect my NPI?	We collect NPI 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. Information in a report prepared by an insurance support organization may be retained by that organization and provided to others.
What NPI do we share?	We may provide to affiliates and/or nonaffiliated third parties the same NPI listed above in the section entitled, "What types of information do we collect?"
How do you safeguard my NPI?	Employees who have access to your NPI 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 request using our online form on our website, ZurichNA.com, or calling our toll-free number at 1-800-382-2150. You may also reasonably describe the information you seek in writing and send your written request to the 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 it is permitted by law. If you request medical records, we may elect to supply that information to you through your designated medical professional for security purposes. 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 through any of the above methods, 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 may make your request using any of the above methods.

Residents of California and Nevada have additional rights over their non-public personal information if it is not governed by the Gramm-Leach-Bliley Act. For more information about these rights, please consult our online privacy policy posted on our website, ZurichNA.com.

FOR RESIDENTS OF MASSACHUSETTS ONLY WHO ARE ZNA P&C CUSTOMERS: 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
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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; and • Responding to insurance regulatory authorities.
Affiliates	Financial or nonfinancial companies related by common ownership or control. • <i>Company affiliates include insurance and non-insurance companies under common ownership with the Company and that provide insurance and non-insurance products or services.</i>

Nonaffiliated Third Parties	Financial or nonfinancial companies not related by common ownership or control. We may share your information with companies that we hire to perform marketing and business services for us, such as data processing, computer software maintenance and development, and transaction processing. When we share information with 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 services. • <i>The Company does not share information with nonaffiliates to market their products to you.</i>
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. • <i>The Company does not jointly market.</i>

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.
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This Privacy Notice is sent on behalf of the following affiliated companies, which are referred to in this Privacy Notice, in the aggregate, as the “Company:”

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 (together, “the ZNA P&C Companies”), Zurich American Life Insurance Company, and Zurich American Life Insurance Company of New York.