

BLANKET ACCIDENT POLICY

HARTFORD FIRE INSURANCE COMPANY

One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)



**THE
HARTFORD**

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Policyholder: Billings Public School

Policy Number: 41-BSR-101246

We will pay benefits according to the conditions of this Policy.

This is a legal contract between the Policyholder and Us. We agree to provide the rights and benefits of this Policy according to its conditions and provisions.

This Policy begins on the Policy Effective Date shown in the Schedule and continues in effect until the Policy Termination Date as long as premiums are paid when due, unless otherwise terminated as further provided in this Policy. If this Policy is terminated, insurance ends on the date to which premiums have been paid. After the Policy Termination Date, this Policy may be renewed for additional periods of time by mutual written consent between Us and the Policyholder at the premium rates set by Us for the renewal period.

PLEASE READ THE POLICY CAREFULLY.

This Policy is delivered in and governed by the laws of the state of Montana. This Policy may be inspected at the office of the Policyholder.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

THIS IS A LIMITED BENEFIT POLICY.

IT PROVIDES BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENT ONLY IT IS NOT INTENDED TO COVER ALL MEDICAL COSTS.

Signed for Hartford Fire Insurance Company at Hartford, Connecticut

Lisa Levin, *Secretary*

Douglas Elliot, *President*

EXCESS INSURANCE

Non-Participating

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SCHEDULE

POLICY NUMBER:	41-BSR-101246
POLICYHOLDER NAME:	Billings Public School
POLICYHOLDER'S ADDRESS:	Lincoln Center, Room 210 Billings, MT 59101-1298

Policy Period:	Policy Effective Date:	8/15/2019
	Policy Termination Date:	8/15/2020

PREMIUM

Policy Premium:	\$16,250
Premium Mode:	annually

DESCRIPTION OF ELIGIBLE CLASS(ES):

Class	Description Of Class(es)	Applicable Hazard Riders	Applicable Benefit Riders
1	All registered students of the Policyholder including student athletes.	N/A	B-1

COVERED ACTIVITIES means: This policy covers each Insured Person during the policy period while he or she is:

- (a) Participating in school related activities sponsored by the Policyholder while on the premises of, designated by and under the direct supervision of the Policyholder, or while participating in or attending an authorized and sponsored activity of the Policyholder while away from the Policyholder's premises.
- (b) Traveling with a group in connection with such activities under the direct supervision of the Policyholder, or
- (c) Traveling directly and uninterruptedly to and from the activities and his or her home or lodging place; or
- (d) While participating as a member of a team in an official tournament, game or practice session in a school sport, including football and wrestling.
- (e) Participating in field trip activities sponsored by the Policyholder while on the premises of, designated by and under the direct supervision of the Policyholder.
- (f) Including adult education classes.

BENEFITS AND AMOUNTS

Class 1	PRINCIPAL SUM
Accidental Death & Dismemberment	\$5,000

EXCESS COVERAGE APPLIES

AGGREGATE LIMIT: \$1,000,000 Per Accident

BENEFIT RIDER(S)

Identifier	Form Number	Description
B-1	Form BSR PA-9935 (MT)	Accident Medical Expense Benefit Rider

DEFINITIONS

Accident, Accidental means a sudden, abrupt, and unexpected event.

Alcohol and Substance Abuse means the overindulgence in or dependence on a stimulant, depressant or other chemical substance, leading to effects that are detrimental to the individual's physical or mental health or the welfare of others.

Ambulatory Surgical Center (ASC) or Ambulatory Medical Center means a licensed healthcare facility where surgical procedures or medical Treatment that does not require an overnight Hospital stay are performed by a Physician. The facility must:

- 1) be under the direct supervision of a Physician;
- 2) provide Treatment by Physicians; and
- 3) have written agreements in place with one or more Hospitals to immediately accept patients who develop complications.

An ASC is also known as an outpatient surgery center or a same day surgery center.

Benefit Plan means a policy or other benefit or service arrangement for medical or dental care, or providing accident or health coverage, under any of the following:

- 1) individual, group or blanket coverage, whether on an insured or self- funded basis;
- 2) Hospital or medical service organizations;
- 3) health maintenance organizations;
- 4) labor-management plans;
- 5) employee benefit organization plans;
- 6) association plans.

Coinsurance means the percentage of the Usual and Customary Charges incurred for Covered Medical Services payable by Us.

Confined, Confinement means the assignment to a bed in a medical facility for a period of at least 24 consecutive hours.

Conveyance means any motorized craft, vehicle, or mode of Transportation licensed or registered by a governmental authority with competent jurisdiction. Conveyances include, but are not limited to, air ambulances, land ambulances and private motor vehicles.

Covered Accident means an Accident that occurs directly and independently of all other causes while coverage is in effect for an Insured Person resulting in a Covered Loss under the Policy for which benefits are payable. The Insured Person must be participating in a Covered Activity, as identified in the Schedule, when the Accident occurs.

Covered Activity means those activities set out in the Covered Activities section of the Schedule, in which Insured Persons are provided insurance under the Policy.

Covered Loss means an accidental death, dismemberment or other Injury covered under the Policy.

Deductible means the amount of Usual and Customary Charges for Covered Medical Services that must be incurred by the Insured Person before benefits become payable. The amount of the Deductible is shown in the Rider Schedule. Benefits are not payable for charges applied to the Deductible.

Diagnostic Exams mean any of the following major/advanced tests: angiogram, arteriogram, bone scintigraphy, CT, EEG, EKG, EMG, MRI, PET, SPECT, or thallium stress test. This definition does not include any lab test or x-ray.

Durable Medical Equipment means equipment of a type that is designed primarily for use, and used primarily, by people who are sick (for example, a wheelchair or a hospital bed). It does not include items commonly used by people who are not sick, even if the items can be used in the Treatment of Emergency Sickness or can be used for rehabilitation or improvement of health (for example, a stationary bicycle or a spa).

Eligible Class means any group of people listed in the Description of Eligible Class(es) shown in the Schedule.

Emergency Room (ER) means a specified area within a Hospital that is designated for emergency healthcare. This area must:

- 1) be staffed and equipped to handle trauma;
- 2) be under the direct supervision of a Physician;
- 3) provide Treatment by Physicians; and
- 4) provide care 24 hours per day, 7 days per week.

This definition does not include an Urgent Care Facility.

Emergency Sickness means an illness or disease diagnosed by a Physician which causes a severe or acute symptom that, if not provided with immediate treatment, would reasonably be expected to result in serious deterioration of the person's health, or place his/her life in jeopardy. Emergency Sickness also includes pregnancy.

Experimental or Investigative Treatment means 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.

Geographic Area means the city, providence or region in which the service, procedure, devices, drugs, treatment or supplies are provided or a greater area, if necessary, to obtain a representation cross-section of charges for a like treatment, service, procedure, device, drug, or supply. Inside the United States, this would be based on the first three digits of the zip code.

Home Health Care means healthcare services provided by a Home Health Care Agency in the residence of an Insured Person, including, but not limited to, counseling services, home health aide services, Hospice Care, skilled nursing care, medical social services and Therapy Services. Services must be rendered under a plan of care that is established and reviewed regularly by a Physician.

Home Health Care Agency means an appropriately licensed home health care agency which:

- 1) is primarily engaged in providing home health services;
- 2) provides services under the supervision of a Physician;
- 3) has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
- 4) maintains clinical records on all patients.

Hospice Care means specialized care, medical services and emotional support for an Insured Person who is in the last stages of an advanced illness, focusing on comfort and quality of life rather than cure.

Hospice Facility means an appropriately licensed healthcare facility, or a distinct unit within a Hospital or other institution, which:

- 1) provides Hospice Care and related services 24 hours per day, 7 days per week;
- 2) is under the direct supervision of a Physician and has a Physician available at all times; and
- 3) is not mainly a place for care of the aged/elderly, care of persons with Substance Abuse issues/disorders, care of persons with Mental and Nervous Disorders, or a hotel or similar establishment.

Confinement in a Hospice Facility must follow certification by a Physician or hospice medical director that an Insured Person is terminally ill with less than 6 months to live if the Covered Loss runs its normal course. This definition does not include a nursing home, Rehabilitation Facility, Skilled Nursing Facility or swing bed hospitals that are authorized to provide and be paid for extended care services.

Hospital means an institution which:

- 1) operates pursuant to law;
- 2) primarily and continuously provides Medical Care and treatment of sick and injured persons on an inpatient basis;
- 3) operates facilities for medical and surgical diagnosis and treatment by or under the supervision of a staff of legally qualified physicians; and
- 4) provides 24 hour a day nursing service by or under the supervision of registered graduate nurses (R.N.).

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

- 1) a nursing home, convalescent home or Skilled Nursing Facility;
- 2) an alcohol or drug treatment facility; or
- 3) a place for rest, custodial care or for the aged.

Immediate Family Member means a person who is related to the Insured Person in any of the following ways: Spouse, brother-in-law, sister-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes step-parent), grand-parent (includes step grand-parent), brother or sister (includes stepbrother or stepsister and half-brother or half-sister), or child (includes a child legally adopted or a child placed for adoption but not yet adopted), or stepchild.

Injury means bodily injury sustained by an Insured Person caused from a Covered Accident that:

- 1) occurs while this Policy is in force as to the Insured Person whose Injury is the basis of claim;
- 2) occurs while the Insured Person is participating in a Covered Activity.

See the Schedule for applicability of all benefits. All Injuries sustained by one Insured Person in any one Covered Accident, including all related conditions and recurrent symptoms of the Injuries are considered a single Injury.

Inpatient means an Insured Person who is Confined and charged by a medical facility for room and board or is being held in a Hospital for a period of 24 consecutive hours or more. The requirement that an Insured Person be charged by the medical facility does not apply to confinement in a Veteran's Administration Hospital or other Federal Government Hospital.

Insured Person means a person:

- 1) who is a member of an Eligible Class described in the Schedule;
- 2) for whom premium has been paid; and
- 3) while covered under this Policy.

Intensive Care Unit (ICU) means a specifically designated area of a Hospital that provides the highest level of Medical Care and:

- 1) is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- 2) is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement;
- 3) is permanently equipped with special lifesaving equipment and medical apparatus for the care of the critically ill or injured;
- 4) is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the unit on a 24 hour basis; and
- 5) has a Physician assigned to the unit on a full-time basis.

An intensive care unit may include Hospital units with the following (or similar) names: burn unit; critical care unit; neonatal intensive care unit; cardiac care unit; or transplant unit.

An intensive care unit is not any of the following step-down units: intermediate care unit; modified/moderate care unit; Observation Unit; progressive care unit; or sub-acute intensive care unit.

This definition does not include a private monitored room.

Medical Care means necessary:

- 1) medical or surgical treatment, services and supplies;
- 2) hospital, nursing and ambulance services.

Each item of Medical Care must be:

- 1) prescribed by a Physician;
- 2) for the sole purpose of treating the Injury.

Medical Emergency Evacuation means, if warranted by the severity of the Insured Person's Injury or Emergency Sickness:

- 1) the Insured Person's immediate Transportation from the place where he or she suffers an Injury or Emergency Sickness to the nearest hospital or other medical facility where appropriate medical treatment can be obtained;
- 2) the Insured Person's Transportation to his or her current place of primary residence to obtain further medical treatment in a hospital or other medical facility or to recover after suffering an Injury or Emergency Sickness and being treated at a local hospital or other medical facility; or
- 3) both 1) and 2) above.

A Medical Emergency Evacuation also includes medical treatment, medical services and medical supplies necessarily received in connection with such Transportation.

Medically Necessary or Medical Necessity means a determination by the Insured Person's Physician that Treatment, service or supply provided to treat an Injury is:

- 1) appropriate and consistent with the diagnosis and does not exceed in scope, duration, or intensity the level of care needed to provide safe, adequate, and appropriate treatment of the Injury;
- 2) is commonly accepted as proper care or treatment of the Injury in accordance with the medical practices of the United States and federal guidelines;
- 3) can reasonably be expected to result in or contribute to the improvement of the Injury; and
- 4) is provided in the most conservative manner or in the least intensive setting without adversely affecting the condition of the Injury or the quality of the Medical Care provided.

The Physician must be acting within the scope of his/her license. A Physician does not include an Insured Person or any Immediate Family Member.

Member of the Household means a person who maintains residence at the same address as the Insured Person at the time of the Injury.

Mental and Nervous Disorders means any condition, disease or disorder listed as a mental or nervous disorder in the most recent edition of the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM), where improvement can be reasonably expected with therapy.

This definition does not include conditions, diseases or disorders related to Substance Abuse.

Observation Unit means a specified unit within a Hospital, apart from an Emergency Room (ER), where a patient can be monitored by a Physician following Treatment in an ER or as an Outpatient. This area must:

- 1) be under the direct supervision of a Physician;
- 2) provide Treatment by Physicians; and
- 3) provide care 24 hours per day, 7 days per week.

Outpatient means an Insured Person who receives Treatment or services at a Hospital, Ambulatory Surgery Center (ASC), lab, medical clinic, Physician's office/clinic, radiologic center or other licensed medical facility and is neither Confined nor charged for room and board.

Physician means a provider or practitioner who:

- 1) is properly licensed or certified to provide care or treatment under the laws of the state where he or she practices;
- 2) provides services that are within the scope of his or her license or certificate; and
- 3) is neither the Insured Person, a Member of the Household of the Insured Person or an Immediate Family Member.

The Insured Person has full freedom of choice in the selection of any health care provider for the Treatment of any Injury related to an Accident within the scope and limitations of his or her practice, including: licensed physician; physician assistant; dentist; osteopath; chiropractor; optometrist; podiatrist; psychologist; licensed social worker; licensed professional counselor; acupuncturist; naturopathic physician; physical therapist; speech-language pathologist; audiologist; licensed addition counselor; licensed marriage and family therapist; or advanced practice registered nurse.

Policy means this insurance policy, certificate, the Schedule and all attached riders, amendments, endorsements or other papers.

Policy Period means the period between the Policy Effective Date and Policy Termination Date. These dates are shown on the Schedule.

Pre-existing Condition means a health condition for which an Insured Person has sought or received medical advice or Treatment from a Physician at any time during the 12 months immediately preceding the Policy Effective Date of coverage under the Policy. Any exclusion related to an Injury that results from, or is caused or contributed to by, a Pre-existing Condition shall only exclude coverage for such condition during the first 12 months after the Insured Person's Effective Date.

Rehabilitation Care Facility means an appropriately licensed healthcare facility, or a distinct unit within a Hospital or other institution, which:

- 1) provides Rehabilitation Care Services;
- 2) is under the direct supervision of a Physician;
- 3) has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
- 4) is not mainly a place for rest, Custodial Care, care of the aged/elderly, care of persons with Substance Abuse issues/disorders, care of persons with Mental and Nervous Disorders, or a hotel or similar establishment.

Confinement in a rehabilitation care facility must be at the direction of a Physician. This definition does not include a Hospice Facility, nursing home, Skilled Nursing Facility or swing bed hospitals that are authorized to provide and be paid for extended care services.

Rehabilitation Care Services means coordinated multidisciplinary physical restorative services (the combined use of medical, social, educational and vocational services) to enable an Insured Person who has experienced a disabling Covered Loss to achieve the highest possible functional ability.

Schedule means the benefits, benefit amounts, terms, limitations, and provisions of coverage selected by the Policyholder which is attached to and made a part of this Policy.

Sickness means an illness, disease or condition that impairs an Insured Person's normal functioning of mind or body and which is not the direct result of an Injury or Accident. Sickness also includes pregnancy.

Skilled Nursing Facility means an appropriately licensed healthcare facility, or a distinct unit within a Hospital or other institution, which:

- 1) provides skilled nursing care and related services 24 hours per day, 7 days per week;
- 2) is under the direct supervision of a Physician and has a Physician available at all times;
- 3) has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
- 4) is not mainly a place for rest, Custodial Care, care of the aged/elderly, care of persons with Substance Abuse issues/disorders, care of persons with Mental and Nervous Disorders, or a hotel or similar establishment.

Confinement in a Skilled Nursing Facility must be at the direction of a Physician. This definition does not include a Hospice Facility, nursing home, Rehabilitation Care Facility or swing bed hospitals that are authorized to provide and be paid for extended care services.

Spouse means any individual who is recognized as the spouse of the Insured Person, under applicable state law.

Spouse will also include a domestic partner or civil union partner as determined by any controlling legal authority or, in the absence of such authority, by agreement between Us and the Policyholder.

Therapy Services means acupuncture, respiratory therapy, occupational therapy, physical therapy or speech therapy.

Transportation means moving an individual by the most efficient and available land, water or air Conveyance.

Treatment means medical advice, diagnosis, care or services (including diagnostic measures) received by a person, or the use of drugs or medicines by a person.

Urgent Care Facility means a licensed, freestanding healthcare facility providing immediate, short-term Medical Care without an appointment, other than a Hospital (including any Outpatient department of a Hospital), Emergency Room, or Physician's office/clinic. The facility must:

- 1) be under the direct supervision of a Physician; and
- 2) provide Treatment by Physicians.

Usual and Customary Charge(s) means the average amount charged by most providers for treatment, service or supplies in the Geographic Area where the treatment, service or supply is provided.

We, Us or Our means the Hartford Fire Insurance Company.

POLICY EFFECTIVE AND TERMINATION DATES

Policy Effective Date

This Policy begins on the Policy Effective Date shown in the Schedule at 12:01 AM Standard Time at the address of the Policyholder where this Policy is delivered.

Policy Termination Date

We may terminate this Policy by giving 45 days advance notice in writing to the Policyholder. Either We or the Policyholder may terminate this Policy on any premium due date by giving 45 days advance notice in writing to the other party.

This Policy may, at any time, be terminated by mutual written consent of the Policyholder and Us.

This Policy terminates automatically on the earlier of:

- 1) the Policy Termination Date shown in the Schedule; or
- 2) the end of the Grace Period if premiums are not paid when due.

Termination takes effect at 12:01 AM Standard Time at the Policyholder's address on the date of termination.

INSURED PERSON'S EFFECTIVE AND TERMINATION DATES

Insured Person's Effective Date

An Insured Person's coverage under this Policy begins on the latest of:

- 1) the Policy Effective Date;
- 2) the date for which the first premium for the Insured Person's coverage is paid; or
- 3) the date the person becomes a member of an Eligible Class as described in the Schedule.

A change in an Insured Person's coverage under this Policy due to a change in his or her Eligible Class, or Covered Activity becomes effective on the later of:

- 1) when the change in his or her Eligible Class, or Covered Activity occurs; or
- 2) if the change requires a change in premium, the date the changed premium is paid.

However, a change in coverage applies only with respect to a Covered Loss that occurs once the change becomes effective.

An Insured Person's newborn and newly adopted children are covered while participating in a Covered Activity from the moment of birth and/or placement for the purpose of adoption for a period of 31 days.

Insured Person's Termination Date

An Insured Person's coverage under this Policy ends on the earliest of:

- 1) the date this Policy is terminated (unless the Policyholder and Us agree, in writing, to permit coverage to continue to the end of the period for which premiums have been paid in lieu of a return of unearned premiums);
- 2) the end of the Grace Period if premiums are not paid when due; or
- 3) the date the Insured Person ceases to be a member of any Eligible Class described in the Schedule.

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 a Covered Accident that occurred while the Insured Person's coverage was in force under this Policy.

PREMIUM

Premiums

Premiums are payable to Us as shown in the Schedule. We may change the required premiums due on any Policy anniversary date, as measured annually from the Policy Effective Date, by giving the Policyholder at least 60 days advance written notice.

We may change the required premiums as a condition of any renewal of this Policy.

We may change the premium rates if failure to increase the premium would:

- 1) place Us in violation of the laws of Montana; or
- 2) cause Our financial impairment to the extent that further transaction of insurance by Us injures or is hazardous to Our policyholder or to the public.

Notice given under this provision must be mailed to the Policyholders last known address as shown by Our records. If We fail to provide the notice required by this provision, coverage will remain in effect at the existing rate with the existing benefits until the full notice period has expired or until the effective date of replacement coverage obtained by the Policyholder.

Renewal

This Policy may be renewed, subject to Our consent, by payment of premiums as they become due. The renewal premiums will be based on Our rates in effect at the time of renewal.

Grace Period

A grace period of 31 days will be provided for the payment of any premium due after the Initial Premium. This Policy will not be terminated for nonpayment of premium during the Grace Period if the Policyholder pays all premiums due by the last day of the Grace Period. This Policy will terminate on the last day of the period for which all premiums have been paid if the Policyholder fails to pay all premiums due by the last day of the Grace Period.

If We expressly agree to accept late payment of a premium without terminating the Policy, the Policyholder will be liable to Us for any unpaid premiums for the time this Policy is in force.

No grace period will be provided if We receive notice to terminate this Policy prior to a premium due date.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFIT(S)

If the Insured Person's Injury results in any of the losses listed in the table below within 365 days after the date of the Covered Accident, We will pay the sum shown opposite the loss. We will not pay more than the Accidental Death or Accidental Dismemberment Principal Sum shown for each Insured Person for all losses due to the same Covered Accident subject to the Age Reduction Schedule. The Accidental Death or Accidental Dismemberment Principal Sum amount is shown in the Schedule.

FOR LOSS OF:

Life.....
Both Hands or Both Feet or Sight of Both Eyes.....
One Hand and One Foot.....
One Hand and Sight of One Eye
One Foot and Sight of One Eye.....
Speech and Hearing in Both Ears.....
Speech and Hearing in One Ear.....
One Arm or One Leg.....
One Hand or One Foot.....
Sight of One Eye.....
Speech or Hearing in Both Ears.....
Thumb and Index Finger on the Same Hand.....
Hearing in One Ear.....
One Thumb.....

BENEFIT:

100% of the Accidental Death Principal Sum
100% of the Accidental Dismemberment Principal Sum
100% of the Accidental Dismemberment Principal Sum
100% of the Accidental Dismemberment Principal Sum
100% of the Accidental Dismemberment Principal Sum
100% of the Accidental Dismemberment Principal Sum
75% of the Accidental Dismemberment Principal Sum
75% of the Accidental Dismemberment Principal Sum
50% of the Accidental Dismemberment Principal Sum
50% of the Accidental Dismemberment Principal Sum
50% of the Accidental Dismemberment Principal Sum
25% of the Accidental Dismemberment Principal Sum
25% of the Accidental Dismemberment Principal Sum
10% of the Accidental Dismemberment Principal Sum

For purposes of this benefit:

- 1) **Loss of Arm** means Severance of an arm above the elbow joint, including the Severance of the entire arm.
- 2) **Loss of Both Feet, Loss of One Foot** means Severance of a foot or both feet above the ankle joint, including the Severance of an entire leg or any part of a leg that includes an entire foot.
- 3) **Loss of Both Hands, Loss of One Hand** means Severance of at least four whole fingers at or proximal to the metacarpophalangeal joints (the joints that connect the fingers and the hand) from one or both hands, including the Severance of an entire arm or any part of an arm that includes an entire hand.
- 4) **Loss of Fingers or Thumb** means Severance of more than one finger or the thumb at least at or proximal to the first interphalangeal joint of each finger.
- 5) **Loss of Hearing** means total and permanent loss of hearing in one or both ears which cannot be corrected by any means.
- 6) **Loss of Leg** means Severance of a leg above the knee joint, including the Severance of the entire leg.
- 7) **Loss of Sight of Both Eyes, Loss of Sight of One Eye** means total and permanent loss of sight or blindness which cannot be corrected by any means, or Severance of one or both eyes.
- 8) **Loss of Speech** means total and permanent loss of audible voice communication which cannot be corrected by any means.
- 9) **Severance** means the complete separation and dismemberment of the part from the body.

Exposure and Disappearance

We will presume an Insured Person has died due to Injuries if, while insurance is in effect, the Insured Person dies as a result of exposure to the elements as a result of an Injury.

We will presume the Insured Person has died if, while insurance is in effect and after the forced landing, stranding, sinking, or wrecking of a vehicle:

- 1) the Insured Person disappears; and
- 2) the Insured Person's body is not found within 1 year of disappearance; and
- 3) a valid death certificate is issued by a court of competent jurisdiction.

LIMITATIONS AND EXCLUSIONS

Economic Sanction

We will not provide coverage or pay benefits under this Policy to the extent, and only to the extent, that We are prohibited from providing coverage or making payment by any type of travel restriction, trade restriction, economic sanction, or embargo imposed by the United States government.

Limitation on Multiple Benefits

If an Insured Person suffers one or more Covered Losses from the same Covered Accident for which amounts are payable under all of the benefits provided by this Policy, the maximum amount payable under all of the benefits combined will not exceed the largest amount payable for one of those Covered Losses.

Limitation on Multiple Covered Activities

If an Insured Person's Injury is caused by a Covered Accident that occurs while the Insured Person is participating in more than one Covered Activity and if the same benefit applies to that Insured Person with respect to more than one such Covered Activity, then the Accidental Death or Accidental Dismemberment Principal Sum for that Insured Person for that Covered Accident will be determined as though the Covered Accident occurred while the Insured Person was participating in only one such Covered Activity. We will pay the benefits for the Covered Activity with the largest Principal Sum for that Insured Person.

Aggregate Limit

The Accidental Death or Accidental Dismemberment Principal Sum otherwise payable shall be reduced if more than one Insured Person suffers a loss as a result of the same Covered Accident, and if amounts are payable for those losses under all of the benefits provided by the Policy.

The Accidental Death or Accidental Dismemberment Principal Sum payable for all such losses for all Insured Persons under all those benefits combined will not exceed the amount shown as the Aggregate Limit in the Schedule or shown on the Hazard Rider Schedule. If the combined Accidental Death or Accidental Dismemberment Principal Sum otherwise payable for all Insured Persons must be reduced to comply with this provision, the reduction will be taken by applying the same percentage of reduction to the individual Accidental Death or Accidental Dismemberment Principal Sum otherwise payable for each Insured Person for all such losses under all those benefits combined.

Exclusions

Unless otherwise specified in the Policy, including any attached Riders, the Policy does not cover loss resulting from or for:

- 1) war or act of war, whether declared or undeclared;
- 2) injury sustained while on active duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard Service is not excluded, unless it extends beyond 31 days;
- 3) injury sustained while on any aircraft except a civil or public aircraft, or military transport aircraft;
- 4) injury sustained while on any aircraft:
 - a) as a pilot, crewmember or student pilot;
 - b) as a flight instructor or examiner;
 - c) if it is owned, operated or leased by or on behalf of the Policyholder, or any Employer or organization covering any Eligible Class under the Policy; or
 - d) being used for tests, experimental purposes, stunt flying, racing or endurance tests;
- 5) injury for which the Insured Person is eligible to receive Workers' Compensation benefits or similar benefits, regardless of whether he or she has applied for the benefits;
- 6) injury sustained by an Insured Person during or as a result of his or her commission of a felony or while incarcerated for a felony, except that this exclusion will not be applicable upon acquittal or dismissal of the felony charges;
- 7) stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;
- 8) sickness, disease, or bacterial or viral infection, or medical or surgical treatment thereof unless and only to the extent covered by Rider, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
- 9) Mental and Nervous Disorders;
- 10) services for which no charge is normally made; or
- 11) any loss incurred while outside the United States, its Territories or Canada.

CLAIMS PROVISIONS

Notice of Claim

The person who has the right to claim benefits (the claimant, beneficiary or his or her representative) must give Us written Notice of a Claim within 30 days after a Covered Loss begins. Failure to furnish notice within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give notice within such time, provided such notice is furnished as soon as reasonably possible. The notice should include the Insured Person's name and the Policy Number. Notice should be given to Our agent or sent to Us.

Claim Forms

When We receive the notice of claim, We will send forms to the claimant for giving Us Proof of Loss. The forms will be sent within 15 days after We receive the notice of claim. If the forms are not received, the claimant will satisfy the Proof of Loss requirement if a written notice of the occurrence, character and extent of the loss is sent to Us.

Proof of Loss

Written Proof of Loss must be furnished to Us within 90 days after the date of the loss. If the claim is for loss of time due to disability, subsequent written proofs of the continuance of such disability must be furnished at such intervals as We 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.

All Proof of Loss submitted must be satisfactory to Us and must include information which is required by Us to adjudicate the claim. In addition, the claimant must provide Us any Proof of Loss documentation specifically required in any relevant Rider. We reserve the right to request additional information reasonably related to the claim.

Time of Payment of Claims

We will pay any benefit due, other than benefits for which the Policy provides periodic payment, immediately after We receive Proof of Loss. Subject to due written Proof of Loss, all accrued benefits for which the Policy provides periodic payment will be paid not later than at the expiration of each period of 30 days during the continuance of the period for which benefits are due, and any balance remaining unpaid at the termination of the period will be paid immediately upon receipt of the proof.

Payment of Claims

We will pay any benefit due and not assigned to the Insured Person, if living. Otherwise, the benefits will be paid according to the written beneficiary designation on file with the Policyholder. If no beneficiary is named or no named beneficiary survives the Insured Person, then We will pay benefits to the Insured Person's estate.

If a benefit due is payable to the Insured Person or a beneficiary who is either a minor or not competent to give a valid release for the payment.

We may pay the benefit due to the parent, guardian, or other person actually supporting the beneficiary.

Upon receipt of due written Proof of Loss, benefit payments for charges incurred by the Insured Person for covered medical services will be made directly to the provider at Our option. If any such charges have been paid by the Insured Person, the benefit payment for those charges will be made to the Insured Person upon written proof of payment.

Appealing Denial of Claims

If a claim for benefits is wholly or partially denied, notice of the decision shall be furnished to the Insured Person. This written decision will:

- 1) give the specific reason or reasons for denial;
- 2) make specific reference to Policy provisions on which the denial is based;
- 3) provide a description of any additional information necessary to prepare the claim and an explanation of why it is necessary; and
- 4) provide an explanation of the review procedure.

On any denied claim, an Insured Person or his representative may appeal to Us for a full and fair review. The claimant may:

- 1) request a review upon written request within 60 days of receipt of claim denial;
- 2) review pertinent documents; and
- 3) submit issues and comments in writing.

We will make a decision no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after We receive the request for review. The written decision will include specific reasons for the decision on which the decision is based.

Subrogation

In the event:

- 1) an Insured Person suffers a Covered Loss caused, in full or in part, by the act or omission of any person or legal entity;
- 2) the Insured Person or claimant becomes entitled to and are paid benefits under the Policy; and
- 3) the Insured Person or claimant does not initiate legal action for the recovery of such benefits from a Third Party in a reasonable period of time or notify Us that he or she does not intend to do so;

then We will be subrogated to any rights such person may have against a Third Party and may, at Our option, bring legal action against or otherwise pursue a Third Party to recover any payments made by Us in connection with the Covered Loss.

If an Insured Person intends to initiate an action for damages against a Third Party, the Insured Person shall give Us reasonable notice. Thereafter, when the Insured Person initiates the legal action for the damages, We may elect to pay a proportionate share of the reasonable costs of the Third-Party action, otherwise Our subrogation right will be reduced by 50%. Our right of subrogation will not be enforced until the Insured Person has been fully compensated for the loss incurred.

Third Party, as used in this provision, means:

- 1) any person or legal entity whose act or omission, in full or in part, causes the Covered Loss for which benefits are paid or payable under the Policy; or
- 2) any insurer, including the Insured Person's own, that provides benefits to the Insured Person or claimant as a result of the act or omission which caused the Covered Loss for which benefits are paid or payable under the Policy.

This provision does not apply to Accidental Death and Dismemberment benefits.

Physical Examinations and Autopsy

We, at our own expense, shall have the right and opportunity to have:

- 1) a claimant for whom a claim is made examined by a Physician of Our choice during the pendency of a claim as often as reasonably required; and
- 2) an autopsy conducted for a claimant for whom a claim is made in case of death, where not prohibited by law.

Legal Actions

No legal action may start:

- 1) until 60 days after Proof of Loss has been given; or
- 2) more than 3 years after the time Proof of Loss is required to be given, unless otherwise required by law.

Assignment

This insurance may not be assigned. The Insured Person may not assign any of his or her rights, privileges or benefits under this Policy. Benefit payments may be assigned as allowed in the Payment of Claims provision.

Workers' Compensation Coverage

The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

GENERAL PROVISIONS

Entire Contract

The entire contract between the Policyholder and Us consists of this Policy, the application, if any, and any other papers made a part of this Policy at issue.

Incontestability

In the absence of fraud, the validity of this Policy shall not be contested, except for nonpayment of premium, after it has been in force for two years from the Policy Effective Date.

Statements

In the absence of fraud, all statements made by the Policyholder and persons insured under this Policy will be deemed representations and not warranties. No statement will be used in any contest unless it is in writing, signed by the person making it and a copy of it is given to the person who made it, or, in the event of the death or incapacity of the Insured Person, to the Insured Person's beneficiary or personal representative.

Changes

No agent has authority to change or waive any part of this Policy. To be valid, any change or waiver must be in writing, approved by one of Our officers and made part of this Policy.

Noncompliance with Policy Requirements

Any express waiver by Us of any requirements of this Policy will not constitute a continuing waiver of such requirements. Any failure by Us to insist upon compliance with any Policy provision will not operate as a waiver or amendment of that provision.

Data Furnished by Policyholder

The Policyholder must maintain adequate records acceptable to Us and provide any information required by Us, relating to this insurance, its premium, and any benefits claimed or paid hereunder.

Right to Audit

We will have the right to inspect and audit, at any reasonable time, all records and procedures of the Policyholder that may have a bearing on this insurance, its premium, and any benefits claimed or paid hereunder.

Certificates

If required by the laws of the state where this Policy is delivered, We will give certificates to the Policyholder for delivery to Insured Persons. The certificates will state the features of this Policy which are important to Insured Persons.

Conformity with Montana Statutes

The provisions of this Policy conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this Policy.

Right to Receive and Release Needed Information

We have the right to decide in Our sole judgment what facts We need to administer this Policy. We may get needed facts from, or give them to, any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Policy must give Us any facts We need to determine coverage under this Policy or determine the correct payment of a claim.

Facility of Payment and Right to Recovery

If a payment made under another plan includes an amount that should have been paid under this Policy, We may pay that amount to the organization making that payment. That amount will then be treated as though it were a benefit paid under this Policy, and We will not have to pay that amount again. If the amount of the payments made by Us is more than it should have paid under this Policy, We may recover the excess from any person(s) to or for whom We have overpaid, including insurance companies or other organizations. If benefits are overpaid, We may recover the amount overpaid by requesting a lump sum payment of the overpaid amount or reducing future benefits payable under this Policy.

New Entrants

This Policy will allow from time to time, that new eligible Insured Persons of the Policyholder be added to the Eligible Class(es) of Insured Persons originally insured under this Policy.

Misstatement of Age

If premiums for the Insured are based on age and the Insured Person 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 Person is insured are based on age and the Insured Person has misstated his or her age, there will be an adjustment of said benefit based on his or her true age. We require satisfactory proof of age before paying any claim.

Clerical Error

Clerical error, whether by the Policyholder or Us, will not void the insurance of any Insured Person 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.

HARTFORD FIRE INSURANCE COMPANY

One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)



The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Policyholder: Billings Public School
Policy Number: 41-BSR-101246

B-1 – ACCIDENTAL MEDICAL EXPENSE BENEFIT RIDER

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider.

ACCIDENT MEDICAL EXPENSE BENEFIT

If an Insured Person suffers an Injury that, within 90 days of the date of the Covered Accident that caused the Injury, requires him or her to be treated by a Physician, We will pay the Usual and Customary Charges incurred for Covered Medical Services that are Medically Necessary and received due to that Injury, up to the Maximum Amount per Insured Person for all Injuries caused by the same Covered Accident. The benefit is payable only for such charges incurred after the Deductible has been met. Benefits are subject to the terms of the Scope of Coverage section. Benefits are then payable for charges incurred within the Maximum Benefit Period shown in the Rider Schedule.

COVERED MEDICAL SERVICES

Covered Medical Services under this Rider are as follows:

- 1) **Hospital:** the following services provided when the Insured Person is Confined in a Hospital:
 - a) the daily room rate for a semi-private room when an Insured Person is Confined in a Hospital and general nursing care is provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.
 - b) ancillary Hospital services and supplies including operating room, laboratory tests, Diagnostic Exams, anesthesia and medicines (excluding take home drugs) when Confined in a Hospital.
 - c) the daily room rate when an Insured Person is Confined in a Hospital in a bed in the Intensive Care Unit; and
 - d) nursing services other than private duty nursing services.
- 2) **Private Duty Nurse:** private duty nursing services by a registered nurse (RN) or licensed practical nurse (LPN) while an Insured Person is Confined in a Hospital. These services must be ordered by a Physician.
- 3) **Emergency Room:** expenses incurred within 72 hours of a Covered Accident due to Treatment in an Emergency Room. Such expenses include the attending Emergency Room Physician's charges, x-rays, laboratory procedures, medications, use of the Emergency Room, and medical supplies.
- 4) **Prosthesis:** artificial limbs, eyes, larynx, or other prosthesis for initial acquisition and fitting. We will not pay for repair or replacement of any prosthesis, unless due to a Covered Accident.
- 5) **Ambulatory Surgical Center or Ambulatory Medical Center:** Treatment including operating room, laboratory tests, anesthesia, medical supplies, and medicines (excluding take home drugs) provided in an Ambulatory Surgical Center or Ambulatory Medical Center.
- 6) **Physician:** expenses for Treatment provided by a Physician.
- 7) **Anesthesia:** expenses for pre-operative screening, anesthetics, and administration of anesthesia during a surgical procedure whether on an Inpatient or Outpatient basis.
- 8) **Durable Medical Equipment Rental:** expenses for rental of a wheelchair, orthopedic appliances, orthopedic braces, or other medical equipment that has therapeutic value for an Insured Person. We will not cover computers, motor vehicles, or modifications to a motor vehicle, ramps and installation costs, eyeglasses, and hearing aids. No benefits will be paid for rental charges in excess of the purchase price.
- 9) **Blood and Blood Products:** expenses for blood, blood products, artificial blood products, and transfusions of any blood or blood products.
- 10) **Ambulance:** expenses for transportation from the emergency site to the Hospital.
- 11) **Radiological Procedures:** Outpatient expenses for CAT Scan, MRI, X-ray, CT, PET, ultrasound, and other radiological procedures. Does not include dental x-rays.

- 12) **Outpatient Laboratory Tests:** expenses for laboratory tests provided when the Insured Person is not confined in a Hospital and provided by a medical facility other than an Emergency Room or Ambulatory Surgical Center.
- 13) **Prescription Drug:** expenses for drugs prescribed by a Physician for the Treatment of Injury and administered on an outpatient basis.
- 14) **Rehabilitation Care Facility:** expenses for physical and occupational rehabilitation. Treatment must be provided in a duly licensed Rehabilitation Care Facility and be under the direction of a Physician.
- 15) **Dental:** expenses including dental x-rays for the repair or Treatment of each injured tooth that is whole, sound, and a natural tooth at the time of the Covered Accident.
- 16) **Vision or Hearing Products:** eyeglasses, contact lenses, and hearing aids when damage occurs in a Covered Accident that requires medical Treatment.
- 17) **Skilled Nursing Facility:** expenses for Confinement in a Skilled Nursing Facility if it begins within 5 consecutive days after an Insured Person is Confined in a Hospital as a result of a Covered Accident. We will pay for Treatment if a Physician visits the Insured Person at least once every 30 days and certifies that the Confinement is Medically Necessary.
- 18) **Home Health Care:** expenses for Home Health Care beginning within 5 consecutive days after discharge from a Hospital, Skilled Nursing Facility, or Rehabilitation Care Facility.
- 19) **Chiropractic Care:** expenses for Treatment and services received by a chiropractor.
- 20) **Physical and Occupational Therapy:** expenses for physical or occupational therapy and an office visit connected with any such service.

RIDER SCHEDULE

ACCIDENT MEDICAL EXPENSE

Maximum Amount per Insured Person:	\$25,000
Deductible:	\$0 per Covered Accident
Coinsurance:	100% of Usual and Customary Charges
Maximum Benefit Period:	52 weeks from the date of the Covered Accident

Covered Medical Services

Maximum Amounts Payable

Hospital:	up to \$235 per day
<ul style="list-style-type: none"> • Maximum Number of Days for Hospital Confinement: • Maximum Number of Days for ICU Confinement: 	30 days 10 days
Emergency Room:	up to \$60 per Covered Accident
Prosthesis:	up to \$500 per Covered Accident
Physician:	
Each Medically Necessary Visit:	up to \$1,000 per visit
Anesthesia:	up to \$300 per procedure
Durable Medical Equipment Rental:	up to \$250 per Covered Accident
Ambulance:	up to \$300 per Covered Accident
Radiological Procedures:	up to \$500 per Covered Accident
Outpatient Laboratory Tests:	up to \$50 per Covered Accident

Dental:	up to \$300 per Covered Accident
Vision or Hearing Products:	up to \$200 per Covered Accident
Chiropractic Care:	
• Maximum per Treatment:	up to \$25
• Maximum Number of Days:	14 days, limited to one Treatment per day
Physical and Occupational Therapy:	
• Maximum per Treatment:	up to \$25
• Maximum Number of Days:	up to 14 days, limited to one Treatment per day

SCOPE OF COVERAGE

Full Excess Benefits

This Rider is secondary coverage to all other policies. We will pay Usual and Customary Charges only when the Usual and Customary Charges are in excess of amounts paid or payable under any other Benefit Plan. We pay benefits without regard to any coordination of benefits provisions in any other Benefit Plan. The amount from other Benefit Plans includes any amount to which the Insured Person is entitled, whether or not a claim is made for the benefits.

Coordination with Medicare

Accident Medical Expense Benefits will be paid in compliance with the Medicare Secondary Payer Act (42 U.S.C. §1395y) and any other applicable law regulating the coordination of benefits of government health Plans. We do not intend to shift to Medicare, Medicaid or any other governmental health Plan with secondary payer status, the responsibility of primary coverage or payment for any Injury for which benefits are payable under this Rider.

LIMITATIONS AND EXCLUSIONS

Rider Exclusions

Unless otherwise specified in this Rider, in addition to the exclusions in the Policy, We will not pay Accident Medical Expense Benefits for any loss, Treatment, or services resulting from, or contributed to, by:

- 1) elective abortion, an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed;
- 2) miscarriage, except as a result of a Covered Accident;
- 3) elective or cosmetic surgery, except for reconstructive surgery needed as the result of an Injury;
- 4) orthopedic appliances used mainly to protect an Injury, so the Insured Person can participate in a Covered Activity
- 5) expenses paid or payable under any automobile insurance policy without regard to fault; (This exclusion does not apply in any state where prohibited.);
- 6) Treatment or service provided by a private duty nurse;
- 7) routine physical exams and medical services or wellness visits;
- 8) overuse symptoms including, but not limited to, bursitis, tendonitis, shin splints, stress fractures, heat exhaustion, heat stroke, heat prostration, malfunctions of the heart, embolism, reinjures or the aggravation thereof, sprains, hernia, strains, muscle tears, or repetitive motion Injury, and/or Treatment of Injuries that result over a period of time (such as blisters, tennis elbow, etc.), and that are a normal result of participation in a Covered Activity, except as specifically provided in the Rider;
- 9) expenses due to an aggravation or re-Injury of a Pre-existing Condition;
- 10) expenses incurred that are in excess of Usual and Customary Charges for Covered Medical Services, or expenses that are not covered;
- 11) Mental and Nervous Disorders;
- 12) Medical Emergency Evacuation;
- 13) Experimental or Investigative Treatment or procedures;
- 14) Treatment of any condition for which the Insured Person is entitled to benefits under any Workers' Compensation Act or similar law.

Out-of-Network Limitation

In the event that an Insured Person is eligible for benefits under this Rider in excess of other medical expense coverage that is primary under a health maintenance organization, preferred provider organization, or similar health service program, a penalty will apply if the Insured Person does 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 this Rider will be reduced by 50%. This reduction shall not apply to an Insured Person in connection with any Treatment for which the health maintenance organization, preferred provider organization or similar health service program provides coverage as if the Insured Person used the facilities or services of the health maintenance organization, preferred provider organization or similar health service program. This limitation is not applicable to out-of-network Treatment provided in an emergency situation.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Covered Medical Services means the services covered by this Rider. Covered Medical Services are shown in the Rider Schedule and described in the Covered Medical Services provision.

In all other respects the Policy remains the same.

Signed for Hartford Fire Insurance Company



Lisa Levin, *Secretary*



Douglas Elliot, *President*