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.

THE HARTFORD

Policyholder: New Hanover County Schools
Policy Number: 36-BSR-103177

POLICY AMENDATORY RIDER

This Rider is attached to and made part of the Policy as of 7/1/2024. 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.

In consideration of the Policy Premium, the Policy Period shall be renewed effective 7/1/2024 to 7/1/2025.

Renewal Policy Premium Due: $24,603.00

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Kevin Barnett, *Secretary*

Michael Ross Fisher, *President*

Form BSR PA-9932

HARTFORD FIRE INSURANCE COMPANY
One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

SCHEDULE

POLICY NUMBER: 36-BSR-103177

POLICYHOLDER NAME: New Hanover County Schools
POLICYHOLDER'S ADDRESS: 6410 Carolina Beach Road
Wilmington, NC 28412

Policy Period:

Policy Effective Date: 7/1/2023
Policy Termination Date: 7/1/2024

PREMIUM

Policy Premium: $19,120.
Premium Mode: annually

DESCRIPTION OF ELIGIBLE CLASS(ES):

Class	Description Of Class(es)	Applicable Hazard Riders	Applicable Benefit Riders
1	All registered student athletes in grades 6th-12th of the Policyholder.	N/A	B-1

COVERED ACTIVITIES means:
This policy covers each Insured Person during the policy period while he or she is:
a) while participating as a member of a team in an official tournament, game or practice session in a school sport; or
(b) traveling with a group in connection with such activities under the direct supervision of Policyholder, or
(c) traveling directly and uninterruptedly to and from the activities and his or her home or lodging place.

BENEFITS AND AMOUNTS

Class 1	Principal Sum
Accidental Death & Dismemberment	$10,000

EXCESS COVERAGE APPLIES

AGGREGATE LIMIT: $500,000 Per Accident

BENEFIT RIDER(S)

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

BLANKET ACCIDENT POLICY

HARTFORD FIRE INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

Policyholder: New Hanover County Schools
Policy Number: 36-BSR-103177

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 Policy issue state, and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (as amended). This Policy may be inspected at the office of the Policyholder.

Important Cancellation Information – Please Read the provision entitled, POLICY EFFECTIVE AND TERMINATION DATES Found On Page 9.

EXCESS INSURANCE

Certain benefits under this Policy are not intended to be issued where other medical insurance exists. If other medical insurance does exist at the time of the claim then the amount of benefits payable by such other medical insurance will become the deductible amount for certain benefits under this Policy if the other medical insurance benefits exceed the deductible amount shown in the Benefit Schedules.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If an Insured Person is eligible for Medicare, he/she should review the Guide to Health Insurance for People with Medicare available from Us.

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

Kevin Barnett, *Secretary*

Michael Ross Fisher, *President*

Non-Participating

Form BSR-1000 (NC)

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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/or Medical Professionals; 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.

Coma, Comatose means a profound state of unconsciousness from which the Insured Person cannot be aroused to consciousness by external or internal stimulation, as determined by a Physician.

Complications of Pregnancy means any condition, whether or not a pregnancy is terminated, that requires Hospital Confinement and whose diagnosis is distinct from pregnancy but is adversely affected or caused by pregnancy. Examples include: acute nephritis; cardiac decompensation; disease of the endocrine, hemopoietic, nervous or vascular systems; ectopic pregnancy that is terminated; hyperemesis gravidarum; missed abortion; nephrosis; non-elective caesarean section; spontaneous termination of pregnancy that occurs during a period of gestation when a viable birth is not possible; or any similar condition(s) of comparable severity.

This definition does not include: elective caesarean section unrelated to a diagnosed complication of pregnancy; false labor; morning sickness; multiple gestation pregnancy; occasional spotting; physician prescribed rest during pregnancy; pre-eclampsia; any similar condition(s) associated with a difficult pregnancy but not considered a classifiable, distinct complication of pregnancy; or any other condition associated with pregnancy but has not been diagnosed by a Physician as a complication of pregnancy as defined.

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/or Medical Professionals; 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 Complications of 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 or Medical Professional;
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 or Medical Professional 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.

Hospital also includes a duly licensed State tax-supported institution, regardless of whether it has an operating room or related equipment for the performance of surgery.

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 fact that a Physician may prescribe, order, recommend, or approve a treatment, service or supply does not, of itself, make the treatment, service, or supply medically necessary for the purpose of determining eligibility for coverage under the Rider.

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

Medical Professional means a person who is appropriately licensed to provide Medical Care and Treatment, including a nurse practitioner (NP/APRN), physician's assistant (PA) or registered nurse (RN). The medical professional must be acting within the scope of his/her license. A medical professional 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 or Medical Professional 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/or Medical Professionals; 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 or Medical Professional'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.

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 or Medical Professional 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 Complications of 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 or Medical Professional 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 or Medical Professional's office/clinic. The facility must:

1) be under the direct supervision of a Physician; and
2) provide Treatment by Physicians and/or Medical Professionals.

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.

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 31 days advance written notice.

We may change the required premiums as a condition of any renewal of this Policy. We may also change the required premiums at any time when any change affecting rates is made in this Policy. Any such change in this Policy will not take effect until any required additional premium is received by Us, except as otherwise agreed to in writing by the Policyholder and Us.

We may change the premium rates if:
1) there is a change in the Policy;
2) there is any change to state or federal law or inaction by state or federal law makers which affects Our liability under the Policy on a temporary or permanent basis;
3) Social Security Disability benefits are reduced or eliminated on a temporary or permanent basis due to the actual or threatened insolvency of the Social Security Disability Insurance Trust Fund;
4) there is a 10% increase or decrease in the number of insured;
5) the Policyholder adds or deletes a subsidiary or affiliated business entity; or
6) there has been a material misstatement in the reported experience during the pre-sale process.

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. The Accidental Death or Accidental Dismemberment Principal Sum amount is shown in the Schedule.

FOR LOSS OF:	BENEFIT:
Life	100% of the Accidental Death Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	100% of the Accidental Dismemberment Principal Sum
One Hand and One Foot	100% of the Accidental Dismemberment Principal Sum
One Hand and Sight of One Eye	100% of the Accidental Dismemberment Principal Sum
One Foot and Sight of One Eye	100% of the Accidental Dismemberment Principal Sum
Speech and Hearing in Both Ears	100% of the Accidental Dismemberment Principal Sum
Speech and Hearing in One Ear	75% of the Accidental Dismemberment Principal Sum
One Arm or One Leg	75% of the Accidental Dismemberment Principal Sum
One Hand or One Foot	50% of the Accidental Dismemberment Principal Sum
Sight of One Eye	50% of the Accidental Dismemberment Principal Sum
Speech or Hearing in Both Ears	50% of the Accidental Dismemberment Principal Sum
Thumb and Index Finger on the Same Hand	25% of the Accidental Dismemberment Principal Sum
Hearing in One Ear	25% of the Accidental Dismemberment Principal Sum
One Thumb	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) suicide or attempted suicide, whether sane or insane, or intentionally self-inflicted injury;
2) war or act of war, whether declared or undeclared (not including acts of terrorism);
3) 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;
4) injury sustained while on any aircraft except a civil or public aircraft, or military transport aircraft;
5) 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;
6) an occupational Injury for which services or supplies for the Treatment thereof are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer, or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act;
7) injury sustained while under the influence of any narcotics, drug or controlled substance, unless administered by or taken according to the instruction of a licensed Physician (This exclusion does not apply to benefits that are payable for hospital, medical, or surgical expenses);
8) injury sustained as a result of the Insured Person's voluntary intoxication through the use of poison, gas or fumes, whether by ingestion, injection, inhalation or absorption;

9) 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;
10) injury sustained while the Insured Person is under the influence of intoxicants (as defined by the law of the jurisdiction in which the Injury occurred);
11) stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;
12) 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;
13) Mental and Nervous Disorders;
14) services for which no charge is normally made.
15) 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. If notice cannot be given within that time, it must be given 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 10 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 180 days after the date of the loss. If the loss is one for which this Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility 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 and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

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 for loss of life:

1) according to the written beneficiary designation on file with the Policyholder; otherwise, if no beneficiary is named or no named beneficiary survives the Insured Person, We will pay
2) to the survivors in equal shares, in the first of the following classes to have a survivor at the Insured Person's death:
    a) Spouse;
    b) children;
    c) parents;
    d) brothers and sisters.

If there is no survivor in these classes or if there are legal impediments to determining who the survivors or beneficiaries are, payment will be made to the Insured Person's estate. All other benefits due and not assigned will be paid to the Insured Person, if living. Otherwise, the benefits will be paid according to the preceding language.

If a benefit due is payable to:

1) the Insured Person's estate; or
2) 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 up to $1,000 of the benefit due to some other person whom We believe is entitled to the payment, and who is related to the Insured Person or the beneficiary by blood or marriage. We will be relieved of further responsibility to the extent of any payment made in good faith. We may pay benefits directly to any Hospital or person rendering covered services, unless the Insured Person requests otherwise in writing. The Insured Person must make the request no later than the time he or she files Proof of Loss.

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.

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 or Medical Professional 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 and any other papers made a part of this Policy at issue.

Incontestability
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 State and Federal Law
Any provision of the Policy that is contrary to the law of the jurisdiction in which it is delivered or with any other applicable law is amended to meet the minimum requirements of the law.

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.

Policy Interpretation

We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy. This provision applies where the interpretation of the Policy is governed by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

HARTFORD FIRE INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

Policyholder: New Hanover County Schools
Policy Number: 36-BSR-103177

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. 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 chiropractic adjustment, spinal manipulation or neck manipulation performed by a licensed health care practitioner.
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
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**
Emergency Room:	up to $750 per Covered Accident
Physician:	
Each Medically Necessary Visit:	up to $250 per visit
Anesthesia:	up to $750 per procedure
Durable Medical Equipment Rental:	up to $250 per Covered Accident
Ambulance:	up to $250 per Covered Accident
Radiological Procedures:	up to $250 per Covered Accident
Outpatient Laboratory Tests:	up to $250 per Covered Accident
Prescription Drug:	up to $250 per Covered Accident
Dental:	up to $500 per tooth
Chiropractic Care:	
• Maximum per Treatment:	up to $50
• Maximum Number of Days:	10 days, limited to one Treatment per day

Physical and Occupational Therapy:

- Maximum per Treatment: up to $50
- Maximum Number of Days: up to 10 days, limited to one Treatment per day

SCOPE OF COVERAGE

Excess Benefits with Corridor Deductible
This provision applies only after the Insured Person satisfies the Deductible and when an Insured Person has Usual and Customary Charges under this Rider and health care coverage under one or more other Benefit Plans. When there is a basis for a claim under this Rider and another Benefit Plan, this Rider is an excess plan which has its benefits determined in excess of the benefits of the other Benefit Plan as described below, unless both:

1) the other Benefit Plan has coordination or excess benefits rules that require its benefits to be determined in excess of the benefits of this Rider; and
2) this Rider has covered the Insured Person longer than the other Benefit Plan has.

When this Rider is an excess plan, the benefits of this Rider for Usual and Customary Charges will be reduced when the sum of:

1) the amount, if any, of this Rider's Deductible that would be applied to the Usual and Customary Charges under this Rider in the absence of this provision; and
2) the benefits that would be payable for Usual and Customary Charges under this Rider in the absence of this provision; and
3) the benefits that would be payable for those same expenses under the other Benefit Plans in the absence of provisions with a purpose like that of a coordination or excess benefits provision, whether or not claim is made;

exceeds the amount of Usual and Customary Charges. In that case, first this Rider's benefits, and next (if necessary) the applied amount of this Rider's Deductible, will be reduced so that this Rider's benefits and applied Deductible amount and the other Benefit Plans' benefits do not total more than the amount of Usual and Customary Charges.

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) pregnancy, childbirth, elective abortion, an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed;
2) Complications of Pregnancy or 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) Treatment or service provided by a private duty nurse;
6) routine physical exams and medical services or wellness visits;
7) 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;
8) expenses due to an aggravation or re-Injury of a Pre-existing Condition;
9) expenses incurred that are in excess of Usual and Customary Charges for Covered Medical Services, or expenses that are not covered;
10) Mental and Nervous Disorders;
11) Medical Emergency Evacuation;
12) Experimental or Investigative Treatment or procedures;

13) an occupational Injury for which services or supplies for the Treatment thereof are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer, or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

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.

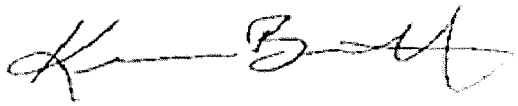
DEFINITIONS

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

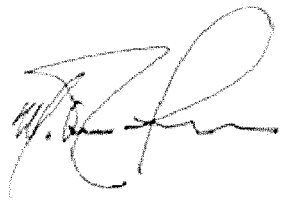
Covered Medical Services means the services covered by this Rider. Covered Medical Services are shown in the Rider Schedule and described in the Covered Medical Services provision.

In all other respects the Policy remains the same.

Signed for Hartford Fire Insurance Company



Kevin Barnett, *Secretary*



Michael Ross Fisher, *President*

STATE NOTICE

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

HARTFORD FIRE INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

NOTICE TO POLICYHOLDERS

Questions or Complaints about Your Coverage

In the event You have questions or complaints regarding any aspect of Your coverage, You may write to us at:

The Hartford
Group Benefits Division, Customer Service
P.O. Box 2999
Hartford, CT 06104-2999

Or call Us at: 1-800-523-2233

When calling, please give Us the following information:

1) the policy number; and

2) the name of the policyholder (employer or organization), as shown in Your Certificate of Insurance.

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the department of Insurance by mail or telephone:

North Carolina Department of Insurance
Consumer Services Division
1201 Mail Service Center
Raleigh, NC 27699-1201

Consumer Services Division: (855) 408-1212