EVEREST REINSURANCE COMPANY

Statutory Office: 251 Little Falls Drive, Wilmington, DE, 19808
Administrative Office: 100 Everest Way, Warren, NJ 07059
800-438-4375

BLANKET ACCIDENT ONLY POLICY

POLICYHOLDER:	Trustee of the Everest Reinsurance Accident and Health Insurance Trust
POLICYHOLDER ADRESS:	c/o The Bank of New York Mellon (Trustee) 101 Barclay Street, NY 10286 Attn: Global Client Solutions – Corporate & Insurance
PARTICIPATING ORGANIZATION:	**Washington Elementary**
EFFECTIVE DATE:	July 1, 2025
POLICY NUMBER:	AHP 1200332-251
POLICY EFFECTIVE DATE:	July 1, 2025
POLICY ANNIVERSARY DATE:	July 1
POLICY TERM	July 1, 2025 – July 1, 2026
POLICY PREMIUM:	$1,360.80
TOTAL PREMIUM:	$1,360.80
PREMIUM MODE:	Annual
DEPOSIT PREMIUM (IF ANY):	N/A
STATE OF ISSUE:	District of Columbia

This Policy describes the terms and conditions of insurance. This Policy goes into effect subject to its applicable terms and conditions at 12:01 A.M. on the Policy Effective Date shown above at the Participating Organization's address. It will remain in effect for the duration of the Policy Term shown above if the premium is paid according to the agreed terms. This Policy terminates at 12:00 A.M., on the day following the last day of the Policy Term unless the Participating Organization and We agreed to continue coverage under this Policy for an additional Policy Term. The laws of the State of Issue govern this Policy. The Policy describes the essential features of the insurance coverage. All benefits are paid according to the terms of the Policy. The Policy is on file with the Participating Organization and may be examined at any reasonable time.

10 DAY RIGHT TO EXAMINE THIS POLICY

Within 10 days after the Participating Organization received the Policy, or notice electronically that the Policy is available, it may be returned in person or by regular mail to the Company, its agency office, or the agent who sold it to the Participating Organization for any reason. The Company will return the premium to the payee. Then the Participating Organization will be in the same position as if the Policy had never been issued.

LIMITED BENEFIT, PLEASE READ THIS POLICY CAREFULLY.

THIS IS ACCIDENT ONLY COVERAGE.
BENEFITS ARE NOT PAYABLE FOR LOSS DUE TO SICKNESS.
THIS POLICY PAYS BENEFITS FOR SPECIFIC LOSSES FROM COVERED ACCIDENTS ONLY.
THIS POLICY IS RENEWABLE.

Signed for **Everest Reinsurance Company** By:

Sylvia Semerdjian, Secretary

Juan Andrade, President

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SCHEDULE OF BENEFITS

The Schedule of Benefits provides a brief outline of the coverage and benefits provided by this Policy. Please read the Description of Hazards section and the Description of Benefits section for full details.

AGGREGATE LIMIT OF LIABILITY

Aggregate Limit per Accident	**$1,000,000**

Class(es) of Eligible Persons

Class	Description of Eligible Classes
1	All enrolled students/athletes, including student trainers, student managers and student coaches of the Participating Organization, grades PreK through 8.
2	All registered participants of summer camps sponsored by the Participating Organization.
3	All registered volunteers of the Participating Organization.

A person may be insured only under one Class of Eligible Persons even though They may be eligible under more than one class. Also, a person may not be insured as a Covered Dependent and an Insured Person at the same time.

Covered Activity	-School Coverage: All Supervised and Sponsored Activities of the Participating Organization, including interscholastic sports. - Participating Organization sponsored summer camps for enrolled and non-enrolled students of the district.

HAZARDS

School Hazard (In Country)	Applicable to Class 1
Supervised and Sponsored Activities Hazard	Applicable to Class 2
Volunteer Activities Coverage Hazard	Applicable to Class 3

BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT	
Principal Sum:	$25,000
Time Period for Loss:	365 days
Covered Loss	**Percentage of Principal Sum**
Loss of Life	100%
Loss of Both Hands	200%
Loss of Both Feet	200%
Loss of Entire Sight of Both Eyes	200%
Loss of One Hand and One Foot	200%
Loss of One Hand and Entire Sight of One Eye	200%
Loss of One Foot and Entire Sight of One Eye	200%
Loss of Speech and Hearing (both ears)	200%
Quadriplegia (Total Paralysis of both upper and lower limbs)	200%
Paraplegia (Total Paralysis of both lower or upper limbs)	200%
Loss of One Hand	100%
Loss of One Foot	100%
Loss of Entire Sight of One Eye	100%
Loss of Speech	100%
Loss of Hearing (both ears)	100%
Loss of Hearing in One Ear	100%
Hemiplegia (Total Paralysis of upper and lower limbs on one side of body)	200%
Uniplegia (Total Paralysis of one lower or upper limb)	200%
Loss of Thumb and Index Finger of the Same Hand	50%

ACCIDENT MEDICAL EXPENSE BENEFIT	
Any benefit limits and benefit percentages for Accident Medical Expense Benefits apply, unless otherwise specified, on a per Covered Person – per Covered Accident basis. Any applicable Deductibles must be satisfied within the time periods specified before benefits are payable.	
Maximum Amount per occurrence	$25,000 per Covered Person
Deductible	$0
Accident Medical Expense benefits may be available on an allocated or unallocated basis as shown. That is to say there may be specific limits or out of pocket expenses on certain Covered Expenses (allocated) or all Covered Expenses may be subject to the same maximum limit and out of pocket expenses (unallocated). Any Deductibles, Benefit Periods, and Maximum Benefit Amounts apply on a per Covered Person, per Covered Accident basis. Any Deductibles apply to all of the below Accident Medical Expense Benefits unless otherwise indicated in the Schedule below.	
First Covered Expenses must be incurred within	90 days, after date of Covered Loss is incurred
Benefit Period	
Basic Medical	2 years
ACCIDENT MEDICAL EXPENSE BENEFIT	
Scope of Coverage	Full Excess
Hospital Room & Board Daily Maximum Benefit Amount	100% of the Semi-Private Room Rate
Intensive Care/Cardiac Care Room & Board	100% of URC up to $25,000
Hospital Miscellaneous Benefit	
Inpatient Maximum Benefit Amount:	100% of URC up to $25,000
Outpatient Maximum Benefit Amount:	100% of URC up to $25,000
Pre-Admission Testing Benefit	100% of URC up to $25,000
Must be incurred within:	7 days
Observation Room	100% of URC up to $25,000
In-Patient Surgical Benefits	
Primary Surgeons Maximum Benefit Amount	100% of URC up to $25,000
Assistant Surgeon Benefit Maximum Benefit Amount	100% of URC up to $25,000
Outpatient Surgery Benefits	
Outpatient Primary Surgeons Maximum Benefit Amount	100% of URC up to $25,000
Outpatient Assistant Surgeon Maximum Benefit Amount	100% of URC up to $25,000
Outpatient Surgical Facility Maximum Benefit Amount	100% of URC up to $25,000
Emergency Room Benefit	100% of URC up to $25,000
Emergency Room Physician	100% of URC up to $25,000
Anesthesia Benefit	100% of URC up to $25,000
Second Opinion Consultation	100% of URC up to $25,000
Neurological Consultant	100% of URC up to $25,000
Physician's Visits	
In-Hospital Maximum Benefit Amount	100% of URC up to $25,000
X-Ray Benefit	
Inpatient Maximum Benefit Amount:	100% of URC up to $25,000 including reading fees
Outpatient Maximum Benefit Amount:	100% of URC up to $25,000 including reading fees
MRI/CAT Scan	100% of URC up to $25,000 including reading fees
Laboratory Benefit	
Inpatient Maximum Benefit Amount:	100% of URC up to $25,000 including reading fees
Outpatient Maximum Benefit Amount:	100% of URC up to $25,000 including reading fees
Diagnostic Imaging Services	

Inpatient Maximum Benefit Amount:	100% of URC up to $25,000 including reading fees
Outpatient Maximum Benefit Amount:	100% of URC up to $25,000 including reading fees
Private Duty Nursing Benefit Amount	100% of URC up to $25,000
Durable Medical Equipment	100% of URC up to $25,000
Orthopedic Braces and Appliances	100% of URC up to $25,000
Prosthetic Devices	100% of URC up to $25,000
Replacement of Eyeglasses Contact Lens and or Hearing Aids	100% of URC up to $25,000
Injections	100% of URC up to $25,000
Outpatient Physiotherapy Benefit	100% of URC up to $25,000
Outpatient Chiropractic Benefit	100% of URC up to $25,000
Physical Therapy Benefit	
Inpatient Maximum Benefit Amount:	100% of URC up to $25,000
Outpatient Maximum Benefit Amount:	100% of URC up to $25,000
Air Ground Ambulance Benefit Amount	100% of URC up to $25,000
Dental Treatment for Injury Only	
Benefit Amount:	100% of URC up to $25,000
ADDITIONAL ACCIDENT BENEFITS Any benefits payable under these Additional Accident Benefits shown below are paid in addition to any Accidental Death and Dismemberment benefits payable, unless otherwise excluded or indicated under the terms, conditions, and exclusions of this Policy. The total of all benefits payable under this Policy, including all Additional Accident Benefits paid for all Injuries caused by the same Covered Accident shall not exceed the Principal Sum indicated in the Schedule of Benefits unless otherwise excluded or indicated under the terms, conditions, and exclusions of this Policy.	
CRISIS DEATH BENEFIT	
Maximum Benefit Amount:	$10,000 per Covered Person Up to a Maximum of $100,000 per incident
Death must occur within:	90 days of the Covered Injury
EXTENDED DENTAL TREATMENT BENEFIT	
Maximum Benefit Amount:	$2,500

DEFINITIONS

The terms shown below shall have the meaning given in this section whenever they appear in this Policy. Additional terms may be defined within the provision to which they apply.

Aircraft means a vehicle which:
1. has a valid Certificate of Airworthiness; and
2. is being flown by a pilot with a valid license appropriate to the Aircraft.

Amateur means a sport or activity where the participants engage largely or entirely without compensation.

Benefit Period means the period of time from the date of Covered Injury, as shown in the Schedule of Benefits.

Child (Children) means the Covered Person's children all of whom are not yet age 26, including:
1. a natural Child from the moment of birth, stepchild, foster, or legally adopted Child; or
2. a Child in the process of adoption (including the Covered Person's adopted Child from the date the Covered Person is a party to a proceeding in which the adoption of such Child is sought); or
3. the Covered Person's civil union partner or Domestic Partner's child(ren) or step child(ren); or
4. a Child for whom the Covered Person is required by a court order to provide medical support; and
5. grandchildren who are dependent on the Covered Person for federal income tax purposes at the time of application.

Civil Union means a same-sex relationship similar to marriage that is recognized as a Civil Union by the District of Columbia.

Club means any league or tournament sponsored sports, social or recreational activity being offered or sponsored by the Participating Organization, or organization of students formed for the purpose of engaging in competition in a particular sport or activity. Competition between student Clubs from different colleges, not organized by and therefore not representing the institution or their faculties, may also be called "Intercollegiate" sports or activities.

Coinsurance means the ratio by which We and the Covered Person share in the payment of Usual and Customary charge for medical treatment. The coinsurance percentage that We will pay is stated in the Schedule of Benefits.

Common Carrier means:
1. a Conveyance, including an Aircraft, licensed for hire to carry fare-paying passengers; or
2. a transport Aircraft operated by the Air Mobility Command of the United States of America or similar air transport service of another country.

It does not include any Aircraft or Conveyance operated for sport, recreation, and/or sightseeing activities or for travel in any Aircraft device for aerial navigation except as expressly provided herein.

Company or **We, Us, Our** means Everest Reinsurance Company, domiciled in Delaware.

Conveyance means a motorized craft, vehicle or mode of transportation licensed or registered by a governmental authority.

Covered Accident means a sudden, unforeseeable external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all the following conditions:
1. occurs while the Covered Person is insured under this Policy;
2. is not contributed to by disease, sickness, or mental or bodily infirmity;
3. is not otherwise excluded under the term of this Policy.

Covered Activity means any recurring activity or event that is shown in the Schedule of Benefits and:
1. takes place under one of the Conditions of Coverage specified in the Schedule of Benefits*;* and
2. is sponsored, organized, scheduled or otherwise provided by the Participating Organization.

Covered Expenses means expenses actually incurred by or on behalf of a Covered Person for the Usual and Customary charges for the Medically Necessary treatment, services and supplies covered by the Policy and which is performed or given under the direction of a Physician for treatment of a Covered Injury. Coverage under the Policy must remain continuously in force from the date of the Accident until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service, or supply, that gave rise to the expense or the charge, was rendered or obtained. A Covered Expense for a Covered Injury cannot be in excess of the Maximum Benefit Amount payable per service as shown in the Schedule and cannot be for medical services and supplies that are excluded under the Policy.

Covered Injury means any bodily harm that results, directly and independently of all other causes, from a Covered Accident. All injuries to the same Covered Person sustained in one Covered Accident, including all related conditions and recurring symptoms of the injuries, will be considered one Covered Injury.

Covered Loss means a loss:
1. which is the result of a Covered Injury to a Covered Person;
2. for which benefits are payable under this Policy; and
3. which is not otherwise excluded under the terms of this Policy.

Covered Person means an Insured Person eligible for coverage as identified in the Schedule of Benefits who is a U.S. citizen residing in the United States, or if not a U.S. citizen, resides permanently in the United States, for whom proper premium payment has been made when due, and who is therefore insured under the Policy.

Covered Short-Term Activity means a Covered Activity that does not recur, is shown in the Schedule of Benefits*,* and:
1. takes place under one of the Hazards specified in the Schedule of Benefits*;* and
2. is sponsored, organized, scheduled or otherwise provided by the Participating Organization.

Dependent means an Insured Person's:
1. lawful Spouse, if not legally separated or divorced, or Domestic Partner or Civil Union Partner.
2. unmarried Children under the age of 26.

Disappearing Deductible means a dollar amount of Covered Expenses the Covered Person must pay before We pay any benefits. The Deductible may be satisfied by Other Valid and Collectible Insurance or Plan. The Disappearing Deductible is shown in the Schedule of Benefits.

Domestic Partner means an unmarried same or opposite sex adult who resides with the Covered Person and has registered in a state or local domestic partner registry with a Covered Person who:
1. for at least 12 consecutive months, has resided with the Covered Person;
2. shared financial assets/obligations with the Covered Person;
3. intend to be life partners;
4. be at least the age of consent in the state in which they reside; and
5. be mentally competent to contract.

Neither the Covered Person nor the Domestic Partner can be related by blood to a degree of closeness that would prohibit a legal marriage, be married to anyone else, or have any other Domestic Partner. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

Emergency Room means a trauma center or special area in a Hospital that is equipped and staffed to give people emergency treatment on an outpatient basis. An Emergency Room is not a clinic or Physician's office. Emergency Room treatment includes all Hospital related services including Physician, x-ray and lab services shown in the Schedule of Benefits.

Health Care Plan means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:

1. group or blanket insurance, whether on an insured or self-funded basis;
2. hospital or medical service organizations on a group basis;
3. Health Maintenance Organizations on a group basis.
4. group labor management plans;
5. employee benefit organization plan;
6. professional association plans on a group basis; or
7. any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended.

Home means the primary residence, structure, or land on which the Covered Person permanently resides.

Home Country means a country from which the Insured Person holds a passport. If the Insured Person holds passports from more than one country, the Home Country will be the country declared to in writing as Their Home Country.

Hospital means an institution which:

1. is operated pursuant to law;
2. is primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis;
3. is under the supervision of a staff of Physicians;
4. provides 24-hour nursing service by or under the supervision of a graduate registered nurse, (R.N.);
5. has medical, diagnostic and treatment facilities, with major surgical facilities;
    a. On its premises; or
    b. Available to it on a prearranged basis; and
6. charges for its services.
7. Is a duly licensed Rehabilitation Facility.

Hospital does not include:

1. a clinic or facility for:
    a. Convalescent, custodial, educational or nursing care;
    b. The aged, drug addicts or alcoholics;
2. a military or veterans' hospital or a hospital contracted for or operated by a national government or its agency unless:
    a. the services are rendered on an emergency basis; and
    b. a legal liability exists for the charges made to the individual for the services given in the absence of insurance.

Hospital Stay means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided for which a per diem charge is made by the Hospital.

Hospital Confinement or Hospital Confined means a stay of 24 or more consecutive hours as a registered resident bed-patient in a Hospital.

Host Country means the country, other than an Excluded Country, in which the Insured Person is traveling while covered under this benefit.

Immediate Family Member means the Covered Person's parent (includes step-parent), grandparent, Spouse, Child(ren) (includes legally adopted or step or Foster Child(ren), brother, sister, step-Child(ren), grandchild(ren), or in-laws. A Member of the Immediate Family includes an individual who normally lives in the Covered Person's household.

Insured Person means an member, as defined under the Schedule of Benefits, who is eligible and for whom the required premium is made making insurance in effect for that person under the Policy. A Dependent covered under the Policy is not an Insured Person.

Interscholastic means a sport or activity organized between Schools or representatives of the Schools.

Intramural means a sport or activity within a particular institution and describes sports matches, activities, or contests that take place among teams from “within the walls” of an institution or area.

Leased Aircraft means an Aircraft for which the Participating Organization or any of its subsidiaries or affiliates has a written lease under whose terms, the Aircraft:
1. can be used at the Participating Organization’s or any of its subsidiaries; or affiliates’ discretion;
2. can be used by the Participating Organization or any of its subsidiaries or affiliates for 2 or more trips or for more than 10 consecutive days; and
3. cannot be altered or sold by the Participating Organization or any of its subsidiaries or affiliates, without the consent of the leaser or owner.

Medically Necessary or Medical Necessity means a treatment, service, or supply that is:
1. required to treat a Covered Injury; and
2. prescribed or ordered by a Physician or furnished by a Hospital;
3. performed in the least costly setting required by the condition;
4. consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

The purchasing or renting of air conditioners, air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them, and general exercise equipment are not considered Medically Necessary.

The fact that a Physician may prescribe, authorize, or direct a service does not in and of itself make it Medically Necessary or covered by the Group Policy.

A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may consider the cost of an alternative to be the Covered Expense.

Normal School Hours means a scheduled period of instruction beginning one half hour before the first scheduled period of instruction of the day begins and ending one half hour after the last scheduled period of instruction of the day ends. If the Covered Person is serving a detention after Normal School Hours, the period is extended until one half hour after the end of the period of detention for that day.

Nurse means either a professional, licensed, graduate Registered Nurse (R.N.) or a professional, Licensed Practical Nurse (L.P.N.).

Operated or Controlled Aircraft means an Aircraft which:
1. has been leased, rented, or borrowed by the Participating Organization for at least 10 consecutive days, or more than 15 days, in any one year;
2. can be used at the Participating Organization’s discretion; and
3. cannot be altered or sold by the Participating Organization without the consent of the owner or leaser.

Operated or Controlled Aircraft does not include any Owned Aircraft.

Other Valid and Collectible Insurance means any reimbursement for or recovery of any element of Covered Expenses incurred available from any other source whatsoever, except gifts and donations, but including without limitation:
1. any individual, group, blanket, or franchise policy of Accident, disability, or health insurance.
2. any arrangement of benefits for members of a group, whether insured or uninsured.
3. any prepaid service arrangement such as BlueCross or BlueShield; individual or group practice plans, or health maintenance organizations.
4. any amount payable for Hospital, medical, or other health services for Accidental bodily Injury arising out of a motor vehicle Accident to the extent such benefits are payable under any medical expense

payment provision (by whatever terminology used including such benefits mandated by law) of any motor vehicle insurance policy.
5. any amount payable for services or injuries or diseases related to the Covered Person's job to the extent that They actually received benefits under a Workers' Compensation Law. If the Covered Person enters into a settlement to give up Their rights to recover future medical expenses that would have been payable except for that settlement.
6. Social Security Disability Benefits, except that Other Medical Insurance shall not include any increase in Social Security Disability Benefits payable to a Covered Person after They become disabled while insured hereunder.
7. any benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.

Owned Aircraft means Aircraft to which the Participating Organization or any of its subsidiaries or affiliates holds legal or equitable title.

Participating Organization means an organization
1. which elects to offer coverage under this Policy by completing a Participating Organization Application for Blanket Accident Insurance that has been accepted by Us;
2. which completes a participation agreement with the Participating Organization;
3. which remits the required premium when due; if applicable; and
4. while coverage through the Participating Organization is available under this Policy.

Personal Deviation means
1. an activity that is not reasonably related to the Covered Person's Covered School Travel and
2. not incidental to the purpose of the trip; and
3. such travel or activities coincide with the Covered Person's Covered School Travel and
4. is with the permission and knowledge of the Participating Organization;

Personal Deviation is limited to any consecutive 7-day period immediately prior to, during, or following such Covered School Travel Covered Sports Travel.

Physician means a person who is a qualified practitioner of medicine. As such, They must be acting within the scope of Their license and under the laws in the state in which They practice and providing only those medical services which are within the scope of Their license or certificate. It does not include a Covered Person, a Covered Person's Spouse, son, daughter, father, mother, brother, or sister or other relative.

Participating Organization means the entity, in whose name the Policy is issued, as identified on the Policy's face page.

Prosthesis means an artificial limb or artificial medical device that is not surgically implanted and that is used to replace a missing limb. The term does not include artificial eyes, ears, noses, dental appliances, ostomy products, or devices such as eyelashes or wigs.

Principal Sum means the largest amount payable under the benefit for all losses resulting from any one Accident.

Rehabilitation Facility means a Hospital or special unit of a Hospital designated as a Rehabilitation Facility or a free-standing facility which provides physical therapy, occupational therapy or speech therapy pursuant to the law of the jurisdiction in which treatment is received.

School means the participating School or School District where the Covered Person is enrolled or employed. The School must be a duly accredited (state certified or accredited) primary, elementary, secondary, or collegiate School.

Spouse means a person of the same or opposite sex who is legally married to the insured under the laws of the state or jurisdiction in which the marriage took place. The term Spouse, where referenced in the Policy shall also mean and include the Covered Person's Domestic Partner or civil union partner.

Strike means any organized and legally sanctioned labor disagreement resulting in a stoppage of work: 1) as a result of a combined effort of workers which was unannounced and unpublished at the time travel services were purchased; and 2) which interferes with the normal departure and arrival of a Common Carrier.

Student Infirmary means an on-campus facility which:
1. provides medical care and treatment to sick and injured students and faculty;
2. is under the supervision of a Physician;
3. provides nursing services; and
4. charges for its services.

Student Infirmary does not include:
1. medical, diagnostic, or treatment facilities with major surgical facilities:
    a. On its premises; or
    b. Available to it on a prearranged basis; or
2. in-patient care.

Supervised and Sponsored Activity means a Participating Organization-authorized function:
1. in which the Covered Person participates;
2. that is organized and approved by the Participating Organization; and
3. that is within the scope of the activities provided by the Participating Organization.

Terrorist Incident means an act of violence, other than civil disorder or riot, (that is not an act of war, declared or undeclared) that results in loss of life or major damage to property by any person acting on behalf of, or in connection with, any organization which is generally recognized as having the intent to overthrow or influence the control of any government.

Their, Them, They refers to male, female, or nonbinary individuals.

Usual Reasonable and Customary (URC) means:
1. with respect to fees or charges, fees for medical services, or supplies which are;
    a. usually charged by the provider for the service or supply given; and
    b. the average charged for the service or supply in the locality in which the service or supply is received; or
2. with respect to treatment or medical services, treatment which is reasonable in relationship to the service or supply given and the severity of the condition.

Waiting Period means the length of time from the date of loss to the time when benefits can be received.

EFFECTIVE DATES OF INSURANCE

Participating Organization Effective Date
The Policy begins on the Policy Effective Date shown in the Schedule of Benefits at 12:01 A.M. at the address of the Participating Organization.

Participating Organization Effective Date
A Participating Organization's coverage under the Policy begins on the later of:
1. Participating Organization Effective Date shown in the Application at 12:01 AM Standard Time at the address of the Participating Organization; or
2. the Policy Effective Date shown in the Application.

Covered Person's Effective Date
A Covered Person will become an insured under this Policy, provided proper premium payment is made, on the latest of:
1. the Effective Date of the Policy; or
2. the day They become eligible , subject to any required Waiting Period, according to the referenced date shown in the Schedule of Benefits.

TERMINATION DATE OF INSURANCE

Policy Termination Date
Termination takes effect at 12:01 A.M. time at the address of the Participating Organization on the date of termination. Termination by the Participating Organization or by Us will be without prejudice to any claims originating prior to the date of termination.

The Policy terminates automatically on the earlier of:
1. the Policy Termination Date shown in the Policy; or
2. the premium due date if premiums are not paid when due subject to any Grace Period.

The Policy may be terminated by the Participating Organization or by Us as of any premium due date or Policy Anniversary Date by giving written notice to the other at least 60 days prior to such date. Written notice of the cancellation will be delivered or mailed to the last address as shown by Our records.

We or the Participating Organization may terminate the Policy at any time by written mutual consent.

If premiums have been paid beyond the termination date, We will refund the excess; or if premiums have been paid short of the termination date, the Participating Organization will owe Us the difference.

Participating Organization Termination Date
Either the Company or the Participating Organization may terminate the Participating Organization's coverage under the Policy on any premium due date by giving 30 days advance written notice to the other party.

The Participating Organization's coverage under the Policy may also, at any time, be terminated by the mutual written consent of the Company and the Participating Organization. A Participating Organization's coverage terminates automatically on the earliest of:
1. the Participating Organization Termination Date shown on the Application;
2. the premium due date if premiums are not paid when due, if applicable; or
3. the date the Policy terminates.

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

Insured Person's Termination
Insurance for an Insured Person will end on the earliest of:
1. the date the Insured Person is no longer in an Eligible Class.
2. the date the Insured Person reports for active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of:
    a. the date the premium is fully earned; or
    b. the Expiration Date of this Policy.

    This does not include Reserve or National Guard duty for training;
3. the end of the period for which the last premium contribution is made; or
4. the date this Policy is terminated.

SCOPE OF COVERAGE

We will provide the benefits described in this Policy to all Covered Persons who suffer a Covered Loss which:

1. is within the scope of the Description of Benefits and results, directly and independently of disease or bodily infirmity, from a Covered Injury which is suffered in a Covered Accident;
2. occurs while the person is a Covered Person under this Policy; and
3. is within the scope of the risks set forth in the Description of Hazards provisions.

Full Excess Accident Medical Expense:
If an injury to the Covered Person occurs while They are in the United States including its territories and jurisdictions and results in Them incurring Covered Expenses for any of the services in the Schedule of Benefits, We will pay the Covered Expenses incurred, subject to the Deductible Amount (if any), that are in excess of Expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan.

The Covered Person must be under the care of a Physician when the Covered Expenses are incurred. The Expense must be incurred solely for the treatment of a Covered Injury:

1. while the person is insured under this Policy; or
2. during the Benefit Period stated in the Schedule of Benefits.

The first Expense must be incurred within the time frame shown in the Schedule of Benefits.

The total of all medical benefits payable under this Policy is shown in the Schedule of Benefits: and

1. subject to the specific maximums shown in the Schedule of Benefits; and
2. subject to compliance with the requirement, set forth in the Limitations section of this Policy.

Non-Duplication of Benefits Provision:
This provision applies if a Covered Person:

1. is covered by any other blanket or group health care plan; and
2. would, as a result, receive total medical expense or service benefits in excess of the expenses actually incurred.

In this case, the Medical Expense Benefits We will pay under this Policy will be reduced by such excess. This provision does not apply if We would be primary under any coordination of benefit guidelines contained in the other Health Care Plans.

Coordination of Benefits Provision:
If a Covered Person is also covered under one or more other Plans, the benefits payable under this Policy will be coordinated with the benefits payable under all other Plans.

Coordination of Benefits will be used to determine the benefits payable for a Covered Person for any Claim Determination Period if, for the Allowable Expenses incurred in that period, the sum of 1. and 2. below would exceed those Allowable Expenses:

1. the benefits that would be payable under this Policy without coordination; and
2. the benefits that would be payable under all other Plans without the coordination of benefits provisions in those Plans.

The benefits that would be payable under this Policy for Allowable Expenses incurred in any Claim Determination Period without Coordination of Benefits will be reduced to the extent required so that the sum of:

1. those required benefits; and
2. all the benefits payable for those Allowable Expenses from all other Plans will not exceed the total of those Allowable Expenses.

Benefits payable under all other Plans include the benefits that would have been payable had proper claim been made for them.

However, the benefits of another Plan will be ignored when the benefits of this Policy are determined if:
1. the Benefit Determination Rules would require this Policy to determine its benefits before that Plan; and
2. the other Plan has a provision that coordinates its benefits with those of this Policy and would, based on its rules, determine its benefits after this Policy.

When Coordination of Benefits reduces the total amount otherwise payable in a Claim Determination Period for a Covered Person, each benefit that would be payable in the absence of Coordination of Benefits will be reduced in proportion. The reduced amount will be charged against any applicable benefit limit of this Policy.

We reserve the right to release to or obtain from any other insurance company or other organization or person, any information that We or it needs for the purpose of the Coordination of Benefits. When payments that should have been made under this Policy based on the terms of this provision have been made under any other Plans, We have the right to pay to any other organization making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered benefits paid under this Policy. We will be released from all liability under this Policy to the extent of these payments. When an overpayment has been made by Us, at any time, We will have the right to recover that payment, to the extent of the excess, from the person to whom it was made or any other insurance company or organization, as We may determine.

Benefit Determination Rules - The rules below establish the order in which benefits will be determined:

1. Benefits not as a Dependent:
The benefits of a Plan that covers the person for whom claim is made other than as a Dependent will be determined before a Plan that covers that person as a Dependent.

2. Dependent Benefits under Different Parent Plans:
The benefits of a Plan that covers the person for whom claim is made as a Dependent of the parent whose birthday falls earlier in the year will be determined before the benefits that covers that person as a Dependent under the other parent's Plan.

When both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
Notwithstanding the foregoing, in the case of a Dependent Child of divorced or separated parents, the following rules will apply:
1. if there is a court decree that establishes financial responsibility for medical, dental or other health care of the Child, the benefits of the Plan that covers the child as a Dependent of the parent so responsible will be determined before any other Plan, otherwise:
2. the benefits of a Plan that covers the Child as a Dependent of the parent with custody will be determined before a Plan that covers the Child as a Dependent of a step-parent or a parent without custody;

The benefits of a Plan that covers the Child as a Dependent of a step-parent will be determined before a Plan that covers the Child as a Dependent of the parent without custody.

3. Benefits for Person Longest Covered:
When the above rules do not establish the order, the benefits of a Plan that has covered the person for whom claim is made for the longer period of time will be determined before a Plan which has covered the person for the shorter period of time.

Whenever used in this provision:

Plan means any:
1. group, blanket or franchise insurance coverage;
2. service plan contracts, group or individual practice or other prepayment plans;
3. coverage under any labor management trusteed Plans, union welfare plans, employer organization plans, self-funded plans or employee benefit organization plans which provides medical or dental benefits or services; or
4. Medicare plan or similar governmental plan offering benefits.

It does not include coverage under individual policies or contracts. Each Plan or part of a Plan that has a right to coordinate benefits will be considered a separate Plan.

Allowable Expense means any necessary, Usual and Customary item of expense at least a part of which is covered by any one of the Plans that covers the person for whom claim is made. When benefits from a Plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid.

Claim Determination Period means a calendar year or that part of a calendar year in which the person has been covered under this Policy.

HMO/PPO PROVISION
In the event that Covered Expenses are denied under a Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), or other group medical plan the Covered Person has in force, and such denial is because care or treatment was received outside of the network's geographic area, benefits will be payable under this coverage, provided the expense is a Covered Expense.

DESCRIPTION OF HAZARDS

Coverage will be provided for the Covered Person only when the Covered Person is engaged in a Hazard as described below and experiences a Covered Loss. Each Hazard is subject to the terms, conditions, limitations, and exclusions contained in this Policy.

Note that the Hazard(s) may be different for each class of Eligible Persons. The Hazard(s) applicable to each Class of Eligible Persons is shown in the Schedule of Benefits.

Unless otherwise specified, We pay benefits only once for any one Covered Accident, even if it is covered by more than one Hazard.

SCHOOL HAZARD (in country)
This Hazard applies to the Covered Person when They suffer a Covered Injury resulting from a Covered Accident that occurs while They are participating in or attending one of the following School Covered Activities:
1. regularly-scheduled classroom instruction;
2. regularly-scheduled and supervised recess or lunch period;
3. a study period or special instruction period supervised by a member of the School's faculty;
4. a Supervised and Sponsored School Activity; or
5. Covered School Travel.

Covered School Travel includes travel, only within the contiguous United States, including Alaska and Hawaii and only directly and without interruption:

1. between Their Home and School;
2. between Their Home and another meeting place designated by the School;
3. between Their Home and another School or site designated by the School, where a Supervised and Sponsored School Activity is scheduled;
4. between the School or other meeting place designated by the School, and another School or site designated by the School, where a Supervised and Sponsored School Activity is scheduled.

School Travel Coverage for Overnight Supervised and Sponsored School Activities:
Covered School travel also includes travel by any Common Carrier providing transportation to a Supervised and Sponsored School Activity, within the contiguous United States, including Alaska and Hawaii when the Covered Person's participation or attendance requires Them to be away from Their Home for a stay of one or more nights. Coverage for travel to any Supervised and Sponsored School Activity that takes place outside the contiguous United States, including Alaska and Hawaii will be covered only if it has been agreed to by us in writing.

Definitions: For the purpose of this Hazard:

Covered School Travel means transportation on a School bus or Private Passenger Automobile driven by a member of the faculty or staff of the School, a parent of the Covered Person, or other adult with a valid drivers' license whom the School has specifically designated to transport the Them to a Supervised and Sponsored School Activity.

Supervised and Sponsored School Activity means a Covered Activity that:
1. takes place:
    a. on School premises during, before or after Normal School Hours; or
    b. at another School or site at which the Covered Activity is scheduled; and
2. is sponsored, organized or otherwise provided, or at which student attendance is required, by the School; and
3. is supervised by a member of the faculty or staff of the School, or by another adult specifically assigned supervisory duties and authority for that Covered Activity by the School or

4. is a regularly-scheduled sports tryout, practice, workout or training session, team meeting, game, exhibition play or competition in which They are participating.

Exclusions:

1. this coverage will not be in effect during travel to or from any Supervised and Sponsored School Activity if:
    a. the School provides transportation to and from it for a group of two or more Covered Persons; and
    b. They are travelling to or from it by another means of transportation.
2. this coverage will not be in effect during Their Personal Deviation.
3. this coverage will not be in effect during travel to any Supervised and Sponsored School Activity that takes place outside the contiguous United States, including Alaska and Hawaii unless We have agreed in advance to provide it.
4. this coverage will not be in effect during a School activity that was not a Supervised and Sponsored School Activity during the preceding School year, unless We have agreed in advance to provide it.

SUPERVISED AND SPONSORED ACTIVITIES HAZARD

This Hazard applies to the Covered Person when They suffer a Covered Injury resulting from a Covered Accident that occurs while They are participating in or attending a Supervised and Sponsored Activity(ies).

The Covered Accident must take place:

1. on the premises of the Participating Organization during normal hours of operation or during scheduled functions; or
2. on the premises of the Participating Organization during other periods if attending or participating in a Covered Activity;
3. away from the premises of the Participating Organization while attending or participating in a Covered Activity at its schedule site.

This coverage includes, travel without delay, deviation or interruption, between Home and the site of the Covered Activity.

Definitions: For the purpose of this Hazard:

Exclusions that apply to this Hazard are in the General Exclusions Section.

VOLUNTEER ACTIVITIES COVERAGE HAZARD

This Hazard applies to the Covered Person when They suffer a Covered Injury resulting from a Covered Accident that occurs while participating as a Volunteer.

The Covered Accident must take place while They are:

1. participating in activities sponsored and supervised by the Participating Organization; or
2. traveling with a group in connection with such activities.

Definitions: For the purpose of this Hazard:

Volunteer means a person who voluntarily offers himself for a service or undertaking; a person who performs a service willingly and without pay.

Exclusions that apply to this Hazard are in the General Exclusions Section.

DESCRIPTION OF BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT
If, within 1 year(s) from the date of a Covered Accident by this Policy, Covered Injury from such Covered Accident, results in Covered Loss listed in the Schedule of Benefits, We will pay the percentage of the Principal Sum set opposite the loss in the table below. If the Covered Person sustains more than one such Covered Loss as the result of one Covered Accident, We will pay only one amount, the largest to which They are entitled. This amount will not exceed the Principal Sum which applies for the Covered Person.

Definitions: For the purpose of this benefit:

Loss of a hand or foot means complete Severance through or above the wrist or ankle joint.

Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

Loss of speech means total, permanent and irrecoverable loss of audible communication.

Loss of hearing means total and permanent loss of hearing in one or both ears which cannot be corrected by any means.

Loss of a thumb and index finger means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

Severance means the complete separation and dismemberment of the part from the body.

Total Paralysis means complete loss of use and sensation of limbs. Paralysis must occur within the 365-day period from the date of the Covered Accident. The paralysis must be determined by a Physician to be complete and not reversible.

ACCIDENT MEDICAL EXPENSE BENEFITS
We will pay Accident Medical Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident. These benefits are subject to the Deductibles, Benefit Periods, Maximum Benefit Amounts and other terms or limits shown below and in the Schedule of Benefits.

Accident Medical Expense Benefits are only payable:
1. for Usual and Customary charges incurred after the Deductible has been met;
2. for those Medically Necessary Covered Expenses incurred by or on behalf of the Covered Person;
3. for Covered Expenses incurred within 90 days after the date of the Covered Accident.

No benefits will be paid for any expenses incurred that are in excess of Usual and Customary charges.

Benefits will be payable for:
1. Hospital semi-private room and board (or, when Medically Necessary, room and board in an intensive care or cardiac care unit); Hospital miscellaneous ancillary services (miscellaneous services include services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services; and supplies. Miscellaneous services do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take-home items, or other convenience items.); Emergency room; or use of an ambulatory medical center;
2. Observation room;
3. Services of an In-Hospital and/or Emergency Room Physician or a registered Private Duty nurse (R.N.);
4. Air and Ground Ambulance service to or from a Hospital;
5. Pre-Admission Testing;
6. Outpatient Physiotherapy including physical therapy and occupational therapy;
7. Rental of Durable Medical Equipment;

8. Artificial limbs, artificial eyes or other prosthetic appliances (not including the replacement of these items);
9. Medicines or drugs administered by a Physician or that can be obtained only with a Physician's written prescription;
10. Dental charges for injury to sound, natural tooth;
11. Medical emergency care (room and supplies) expenses: incurred within 72 hours of an Accident and including: the attending Physician's charges; X-rays; laboratory procedures; use of the Emergency Room; and supplies;
12. Inpatient and/or Outpatient surgical room and supply expenses for use of the surgical facility; Services of Inpatient and/or Outpatient Primary and Assistant surgeons;
13. Outpatient: diagnostic X-rays; MRI/CAT scans; laboratory procedures; diagnostic imaging services; and tests;
14. Inpatient and/or Outpatient Physician non-surgical treatment/examination expenses (excluding medicines) including: the Physician's initial visit; each Medically Necessary follow-up visit; and consultation visits when referred by the attending Physician;
15. Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis;
16. Chiropractic expenses on an outpatient basis limited to one visit per day;
17. Eyeglasses; contact lenses; and hearing aids; when damage occurs in a Covered Accident that requires medical treatment;
18. Injections;
19. In-Patient Rehabilitative Services, including Skilled Nursing and Sub-Acute Facility Care.
20. Home Health Care;
21. Motor Vehicle Accidents;
22. Orthopedic braces and appliances.
23. Expenses due to an aggravation or re-Injury of a pre-existing condition;
24. Expenses for treatment of heat stroke, heart attack, stroke, and burst aneurysm if the condition occurs as the result of a Covered Accident.
25. Expenses for treatment of the following conditions resulting from the play or practice of sports: repetitive motion injuries; strains; sprains; hernia; tennis elbow; tendonitis; bursitis; and muscle tears

Excluded Expenses

The following will not be considered Covered Expenses unless coverage is specifically provided.

1. Any service, treatment or supply that is not considered appropriate treatment as defined in this Policy.
2. Expenses Incurred after the end of the Benefit Period, even if Incurred for continuing services or treatment of a Covered Injury.
3. Whole blood, concentrated red blood cells or blood storage except expenses by a Hospital for processing or administration of blood.
4. cosmetic surgery or care, or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to:
    a cosmetic surgery resulting from a Covered Accident, if initial treatment of the Covered Person is begun within 12 months of the date of the Covered Accident;
    b reconstruction incidental to or following surgery resulting from a Covered Accident;
    c. any unplanned and unintended adverse consequences that may result during the treatment of a Covered Accident.
5. Any elective or routine treatment, surgery, health treatment, or examination, including any service, treatment or supplies that: (a) are deemed to be experimental or investigational; and (b) are not recognized and generally accepted medical practice in the United States.
6. Services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay.
7. Rest cures or custodial care.
8. Personal services such as television and telephone.
9. sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural foreseeable result of an accidental external bodily injury or accidental food poisoning.
10. Routine dental care and treatment.
11. Routine nursery care.

Other Exclusions that apply to this benefit are in the *General Exclusions* Section.

ADDITIONAL ACCIDENT BENEFITS

CRISIS DEATH BENEFIT
We will pay the benefit shown in the Schedule of Benefits, subject to all applicable conditions and exclusions, if one or more Covered Person's death results, directly and independently of all other causes, from another person's use of a gun, a knife or other deadly weapon to commit an Act of Violence while insurance under this Policy is in effect. Such an Act of Violence must occur:

1. on School premises during Normal School Hours; or
2. during a Covered Activity.

The Maximum shown in the Schedule of Benefits will be divided equally among all Covered Persons killed if the benefit payable for each person multiplied by the number of benefits payable for any one Covered Accident would exceed that Maximum.

Definitions: For the purpose of this benefit:

Act of Violence means an action resulting in a fatal injury inflicted by a person with malicious intent to cause bodily harm.

Exclusions:
Benefits will not be payable if:

1. the Act of Violence occurs while They are traveling to and from School *or* to and from a Covered Activity
2. They produce or obtain a gun, a knife or other deadly weapon during the incident and are killed, whether or not They are acting in self-defense.

Other exclusions that apply to this benefit are in the General Exclusions Section.

EXTENDED DENTAL TREATMENT BENEFIT
Benefits are payable for the Usual and Customary expenses incurred within 10 years from the date of the Covered Accident or up until the Covered Persons reaches the age of twenty-one (21) years of age for treatment, repair, and replacement of each injured natural tooth, including examination, diagnosis, x-ray, restorative treatment, endodontic, oral surgery, and replacement of caps, crowns, dentures and orthodontic appliances. Treatment must begin within 90 days after the Covered Accident causing the Covered Injury. Coverage is 24 hours. Benefits will be payable for any Covered Accident which happens to Them while They are covered by this Policy.

GENERAL LIMITATIONS

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

GENERAL EXCLUSIONS

This Policy does not cover any loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of any of the following even if the immediate cause of the loss is an Accidental bodily Injury, unless otherwise covered under this Policy by Additional Benefits:

1. Suicide, self-destruction, attempted self-destruction or intentional self-inflicted Injury while sane or insane.
2. War or any act of war, declared or undeclared.
3. An Accident which occurs while the Covered Person is on Active Duty in any Armed Forces, National Guard, military, naval or air service or organized reserve corps:
4. Injury sustained while in the service of the armed forces of any country. When the Covered Person enters the armed forces of any country, We will refund the unearned pro-rata premium upon request;
5. Participation in a riot or insurrection. Riot means a public disturbance involving an assemblage of 5 or more persons which by tumultuous and violent conduct or the threat thereof creates grave danger of damage or injury to property or persons. An exclusion for riot shall apply only when a person willfully engages in a riot or willfully incites or urges other persons to engage in a riot.
6. Any Injury requiring treatment which arises out of, or in the course of fighting, brawling, assault or battery.
7. sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural foreseeable result of an Accidental external bodily injury or accidental food poisoning.
8. Disease or disorder of the body or mind.
9. Mental or Nervous disorders, except as specifically provided in the Policy.
10. Asphyxiation from voluntarily or involuntarily inhaling gas and not the result of the Covered Person's job.
11. Voluntarily taking any drug or narcotic unless the drug or narcotic is prescribed by a Physician and not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
12. Intoxication or being under the influence of any drug or narcotic.
13. Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
14. Driving under the influence of a controlled substance unless administered on the advice of a Physician.
15. Driving while Intoxicated. Intoxicated will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs.
16. Violation or in violation or attempt to violate any duly-enacted law or regulation, or commission or attempt to commit an assault or felony, or that occurs while engaged in an illegal occupation.
17. Conditions that are not caused by a Covered Accident.
18. Covered Expenses for which the Covered Person would not be responsible in the absence of this Policy.
19. Any treatment, service or supply not specifically covered by this Policy.
20. Loss resulting from participation in any activity not specifically covered by this Policy.
21. Charges which are in excess of Usual and Customary charges.
22. Expenses incurred for an Accident after the Benefit Period shown in the Schedule of Benefits.
23. Regular health checkups.
24. Travel or activity outside the United States.
25. Any Accident where the Covered Person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license.
26. Travel in or upon:
    a. A snowmobile;
    b. A water jet ski;
    c. Any two or three wheeled motor vehicle, other than a motorcycle registered for on-road travel;
    d. Any off-road motorized vehicle not requiring licensing as a motor vehicle;

27. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
    a. While riding as a passenger in any Aircraft not intended or licensed for the transportation of passengers; or
    b. While being used for any test or experimental purpose; or
    c. While piloting, operation, learning to operate or serving as a member of the crew thereof; or
    d. While traveling in any such Aircraft or device which is owned or leased by or on behalf of the Participating Organization of any subsidiary or affiliate of the Participating Organization, or by the Covered Person or any member of Their household.
    e. A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
    f. an ultralight hang-gliding, parachuting, or bungee-cord jumping
    g. Except as a fare paying passenger on a regularly scheduled commercial airline or as a passenger in a non-scheduled, private Aircraft used for business or pleasure purposes.
28. Treatment for an Injury that is caused by or results from a nuclear reaction or the release of nuclear energy. However, this exclusion will not apply if the loss is sustained within 365 days of the initial incident and:
    a. The loss was caused by fire, heat, explosion or other physical trauma which was a result of the release of nuclear energy and
    b. The Covered Person was within a 100-mile radius of the site of release either:
        i. At the time of the release; or
        ii. Within 24 hours of the start of the release; or
        iii. Occurs while the Covered Person is in
29. Rest cures or custodial care.
30. Elective or Cosmetic surgery, except for reconstructive surgery on an injured part of the body.
31. Services rendered for detection and correction by manual or mechanical means (including x-rays incidental thereto of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.
32. Pregnancy (except complications of pregnancy); childbirth; miscarriage; abortion; or any complications of any of these conditions. This does not apply if treatment is required as a result of a Covered Accident.

AGGREGATE LIMIT

The maximum amount payable under this Policy may be reduced if more than one Covered Person suffers a loss as a result of the same accident, and if amounts are payable for those losses under one or more of the following Hazards and Benefits provided by this Policy: School Hazard (In-Country). The maximum amount payable for all such losses for all Covered Persons under all those Benefits combined will not exceed the amount shown as the Aggregate Limit in the Schedule of Benefits. If the combined maximum amount otherwise payable for all Covered Persons must be reduced to comply with this provision, the reduction will be taken by applying the same percentage of reduction to the individual maximum amount otherwise payable for each Covered Person for all such losses under all those Benefits combined.

PREMIUM PROVISIONS

GRACE PERIOD:
A grace period of 31 days is granted for each premium due after the first premium due date. Coverage will stay in force during this period unless notice has been sent, in accordance with the Policy Termination provision, of the intent to terminate coverage under this Policy. Coverage will end if the premium is not paid by the end of the Grace Period.

PREMIUMS:
Premium due dates are the first of every month. Premium payment made in advance or for more than a one month period will not affect any provisions of this Policy with regard to change. Failure by the Participating Organization to pay premiums when due or within the grace period shall be deemed notice to Us to terminate coverage at the end of the period for which premium was paid.

CHANGES IN RATES:
We have the right to change the premium rates on any premium due date:
1. after the first 12 months insurance is in effect;
2. coinciding with a change in the coverage provided or classes eligible; or
3. coinciding with a change in the risks We have assumed.

We will give 45 days written notice of any change under 1. above. Notice will be sent to the Participating Organization's most recent address in Our records.

GENERAL PROVISIONS

ENTIRE CONTRACT
The entire contract consists of the Policy, the Application, Riders, and any other documents requested and accepted by Us. No change in this Policy is valid unless approved by an officer of the Company. Such approval must be signed by Our officer and attached to this Policy. No broker, agent or producer can change or waive any provision of this Policy.

AMENDMENTS
Any change in this Policy will be made by amendment and approved by Us. Such amendment will not require the consent of any Covered Person. The effective time for any amendments shall be 12:01 A.M. Standard Time at the address of the Insured.

TIME LIMITS ON CERTAIN DEFENSES
All statements made by the Participating Organization or by a Covered Person are deemed representations and not warranties. No such statement will cause Us to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is or has been furnished to such person; or, in the event of Their death or incapacity, Their beneficiary or representative. After 3 years from the Covered Person's Effective Date of coverage, no such statement, except in the case of fraud or with respect to eligibility for coverage, will cause such coverage to be contested.

MISSTATEMENT OF AGE
If the age of the Covered Person is incorrectly stated, We will make a fair adjustment of the premiums, benefits, or both. The adjustment will be based on the premiums and benefits that would have been payable had We known the correct information.

WORKERS' COMPENSATION INSURANCE:
This Policy is not in lieu of and does not affect any requirement for coverage under any Workers' Compensation Insurance.

POLICY TERMINATION:
We may terminate coverage on or after the anniversary of any premium due date. The Participating Organization may terminate its coverage on any premium due date. Written notice must be given at least 31 days prior to such premium due date.

CONFORMITY WITH STATE STATUTES:
Any provision of this Policy in conflict, on the Effective Date of this Policy, with the laws of the state where it is delivered, is amended to conform to the minimum requirements of such laws.

CLERICAL ERROR
Clerical errors that We or Our authorized Administrator make in Your Schedule of Benefits, the issuance of a Policy, or in record keeping will not afford You benefits or validate insurance for which You have not applied and paid the appropriate premium and been approved by Us. We have the right to offset or recover from You any overpayment of benefits made due to such errors.

NON-WAIVER
If We or You fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of this Policy, that will not be considered a waiver of any rights under the Policy. . A past failure to strictly enforce the Policy will not be a waiver of any rights in the future, even in the same situation or set of facts.

REINSTATEMENT
This Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are Your written application satisfactory to Us and payment of all overdue premiums. This Policy with be reinstated upon approval of such application or, lacking such approval, upon the 45th day following the date of such conditional receipt unless You have been previously notified in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from the (accidental loss) benefits listed in this Policy as may be sustained after the date of reinstatement and loss due to such sickness as

may begin more than 10 days after such date. In all other respects You and We shall have the same rights thereunder as they had under this Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

ADVISORY NOTICE TO PARTICIPATING ORGANIZATIONS REGARDING TRADE OR ECONOMIC SANCTIONS

This Notice supersedes any provision in the Policy pertaining to Trade or Economic Sanctions.

No coverage is provided by this Participating Organization Notice nor can it be construed to replace any provisions of your policy. You should read your policy and review your Declarations page for complete information on the coverages you are provided.

This Notice provides information concerning possible impact on your insurance coverage due to any applicable trade or economic sanctions law or regulation, including but not limited to, trade or economic sanctions laws or regulations of the United Nations, European Union, Switzerland, United Kingdom, Canada or the United States Treasury Department's Office of Foreign Assets Control (OFAC).

Please read this Notice carefully.

OFAC administers and enforces sanctions policy, based on Presidential declarations of "national emergency". OFAC has identified and listed numerous:

- Foreign agents;
- Front organizations;
- Terrorists;
- Terrorist organizations; and
- Narcotics traffickers;

as "Specially Designated Nationals and Blocked Persons". This list can be located on the United States Treasury's web site – http//www.treas.gov/ofac.

If it is determined that You or any other insured, or any person or entity claiming the benefits of this insurance have violated any applicable trade or economic sanctions laws or regulations, including but not limited to those of the United Nations, European Union, Switzerland, United Kingdom, Canada or the United States Treasury Department's Office of Foreign Assets Control, this insurance will be considered a blocked or frozen contract and all provisions of this insurance are immediately subject to restrictions. When an insurance policy is considered such a blocked or frozen contract, no payments or premium refunds may be made without authorization from the applicable regulator. Other limitations on the premiums and payments also apply.

CLAIM PROVISIONS

NOTICE OF CLAIM:
Written notice of claim must be given to Us within 60 days after a Covered Loss occurs or begins or as soon as reasonably possible. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. Notice can be given at Our administrative office as shown on the cover page or to Our agent. Notice should include the Participating Organization's name and number and a Covered Person's name and address.

CLAIM FORMS:
When We receive the Notice of Claim, We will send forms for filing Proof of Loss. If claim forms are not sent within 15 days after notice is given, the proof requirements will be met by submitting, within the time required under Proof of Loss, written proof of the nature and extent of the loss.

PROOF OF LOSS:
Written Proof of Loss must be furnished to Us in the case of a claim for loss for which this Policy provides periodic payment contingent upon continuing loss within 90 days after the end of the period for which We are liable. Written proof that the loss continues must be furnished to Us at intervals required by Us.

In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss.

If that is not reasonably possible, We will not deny or reduce any claim if proof is furnished as soon as reasonably possible. Proof must, in any case, be furnished not more than a year later, except for lack of legal capacity.

TIME OF PAYMENT OF CLAIMS:
Benefits due under this Policy for a loss, other than a loss for which this Policy provides installments, will be paid immediately upon receipt of due written proof of such loss. Subject to written Proof of Loss, all accrued benefits for loss for which this Policy provides installments will be paid monthly. Any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of a written Proof of Loss, unless otherwise stated in the Description of Benefits.

PAYMENT OF CLAIMS:
All benefits will be paid to the Covered Person if living. Benefits for a Covered Person's loss of life will be paid to the beneficiary named in Our records, if any, at the time of payment. The benefits can be paid in one sum or, at a Covered Person's written request, in accordance with one of Our settlement plans. If a Covered Person has not requested any settlement plan, the beneficiary can do so in writing after a Covered Person's death. If there is no named beneficiary or surviving beneficiary, a Covered Person's loss of life benefits will be paid in one sum to the first surviving class of following in the order shown below:

1. the beneficiary named to receive a Covered Person's proceeds;
2. Spouse;
3. Child or Children;
4. mother or father;
5. sisters or brothers;
6. the estate of a Covered Person; or
7. the Covered Person's group life insurance beneficiary designation.

If We are to pay benefits to the estate, We may pay up to $1,000 to a relative by blood or marriage whom We believe is equitably entitled. This good faith payment satisfies Our legal duty to the extent of that payment.

PAYMENT OF CLAIMS: OTHER BENEFITS:
All other benefits will be paid to the Covered Person, if They are living, if not, We will pay Their beneficiary or Their estate.

CHANGE OF BENEFICIARY:
The Covered Person can change the beneficiary at any time by giving Us written notice. The beneficiary's consent is not required for this or any other change which a Covered Person may make unless the designation of beneficiary is irrevocable or otherwise required by law.

PHYSICAL EXAMINATION AND AUTOPSY:
We will pay the cost and have the right to have the Covered Person examined as often as reasonably necessary while the claim is pending. We can have an autopsy made at Our expense unless prohibited by law. (Autopsies are not permitted to be required in Massachusetts, Mississippi and South Carolina.)

RECOVERY OF BENEFITS:
We reserve the right to recover from a Covered Person any benefits We have paid to for injuries:
1. received in a Covered Accident; and
2. which are covered under:
    a. Workers' Compensation or similar statutory remedies available under law; or
    b. any employer's liability Insurance.

It will be assumed that the Covered Person is in receipt of such benefits unless They give Us proof such benefits have been denied to Them.

SUBROGATION:
If We have paid benefits to a Covered Person for Injuries received in a Covered Accident, and a third party may be liable, We will be subrogated to the extent of such payment and to all of the rights of the Covered Person regarding the recovery of benefits paid or to any settlement or judgment which results from the exercise of these rights. The Covered Person agrees to sign papers and do whatever else is necessary to transfer Ther rights to Us. We will exercise such rights on Their behalf. They further agree to furnish Us with all relevant information and documents.

LEGAL ACTIONS:
No action at law or in equity shall be brought to recover benefits under this Policy less than 60 days after written proof of loss has been furnished as required by this Policy. No such action shall be brought more than 3 years after the time written proof of loss is required to be furnished.