Hartford Fire Insurance Company

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

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



This health plan, alone, **does not meet Minimum Creditable Coverage standards** and **will not satisfy** the individual mandate that individuals have health insurance. Please see below for additional information.

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This plan is not intended to provide comprehensive health care coverage and **does not meet Minimum Creditable Coverage standards**, even if it does include services that are not available in the Insured Person's other health plans.

SCHEDULE

POLICY NUMBER	**10-BSR-104934**
POLICYHOLDER NAME **POLICYHOLDER'S ADDRESS:**	**Bourne Public Schools** 36 Sandwich Road Bourne, MA 02532
Policy Period:	Policy Effective Date: 08/01/2025
	Policy Termination Date: 08/01/2026

PREMIUM

Policy Premium:	$8,924.00
Premium Mode:	Annually

DESCRIPTION OF ELIGIBLE CLASS(ES):

Class	Description Of Class(es)	Applicable Hazard Riders	Applicable Benefit Riders
1	All enrolled students of the Policyholder while participating in Policyholder sponsored and supervised sports activities and enrolled students while traveling to and from Policyholder sponsored School-to-Work and Internship Programs.	N/A	B-61
2	All enrolled students of the Policyholder while participating in Policyholder sponsored Non-Athletic Field Trips	N/A	B-61
3	All enrolled students of the Policyholder, unpaid chaperones, unpaid volunteers such as cafeteria workers, hall monitors, volunteer office staff, day care workers, playground monitors while participate in School Trips and Special Activities	N/A	B-61

COVERED ACTIVITIES means:

Class 1: This policy covers each Insured Person during the policy period while he or she is:
(a) participating in Policyholder sponsored and supervised sports activities, including Junior High School Sports and Senior High School Sports, Band and Cheerleading. Coverage is also included while participating in officially scheduled and authorized Off Season Physical Conditioning sessions, established by and under the direct supervision of a regularly employed coach or trainer, while on the premises of, or designated by the Policyholder. Off Season Physical Conditioning means any activity listed herein which is not the play or practice involving bodily contact of any sport which is performed in accordance with the above. The activities which will be covered for Off Season Physical Conditioning include, but are not limited to: running, swimming, rope jumping, cycling, weight training, calisthenics and aerobic exercises; or
(b) participating in Policyholder sponsored and supervised PE Classes, while on the Policyholder's premises or premises designated by the Policyholder; or
(c) traveling with a group in connection with such activities under the direct supervision of Policyholder.
(d) traveling to and from Policyholder sponsored School-to-Work and Internship Programs, this includes unsupervised, private transportation.

Class 2: This policy covers each Insured Person during the policy period while he or she is participating in or attending a Non-Athletic Field Trips. **Non-Athletic Field Trips** means Policyholder sponsored and supervised non-athletic field trips for extracurricular activity, whether or not school is in session.
This includes necessary traveling directly between his home or from the Policyholder and the location of a Policyholder sponsored non-athletic field trip or extracurricular activity whether or not school is in session. Such traveling must be under adult supervision provided by Policyholder. When travel is by other than Policyholder bus, covered travel time shall not exceed one hour each way. This includes traveling to or from the Insured's home, the Policyholder address, or a Policyholder sponsored non-athletic field trip or extracurricular activity. The covered travel time includes the period before the Insured's required attendance time and the period after his dismissal or when he completes any extra duties. Overnight Field Trips, field trips of more than one day, and out-of-state field trips are not covered unless the appropriate additional premium has been paid.

Class 3: This policy covers each Insured Person during the policy period while he or she is participating in School Trips and Special Activities. **School Trips and Special Activities** is defined as:
(a) All overnight school sponsored class trips and field trips, including trips to Europe, that are not included in the Non-Athletic Field Trip Coverage ; or
(b) All school sponsored overnight athletic trips (for example Ski Trips); or
(c) Coverage for all participants of the Junior & Senior Prom as sponsored and supervised by the school while on school premises or on premises as specified by the school; or
(d) After school detention on the premises of the school district; or
(e) K-8 on school premises after class school sponsored Day Care Programs; or
(f) SCHOOL TO WORK programs as part of their curriculum including VO-TECH programs; or
(g) Civic projects, fund raisers and beautification projects.
Travel to and from any of the activities listed in this rider will be covered only when transportation is provided by the school as a group.

BENEFITS AND AMOUNTS

	PRINCIPAL SUM
Class 1 & 3	
Accidental Death & Dismemberment	$20,000
Class 2	
Accidental Death & Dismemberment	$1,000

EXCESS COVERAGE APPLIES

AGGREGATE LIMIT: $500,000 Per Accident

BENEFIT RIDER(S)

Identifier	Form Number	Description
B-61	Form BSR PA-10433 (EDU) (SU) (MA) (Rev-1)	Enhanced Accident Medical Expense Benefit Rider

BLANKET ACCIDENT POLICY

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

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

Policyholder: Bourne Public Schools
Policy Number: 10-BSR-104934

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.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

THIS IS A LIMITED BENEFIT POLICY.
IT PROVIDES BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENT ONLY. IT IS NOT INTENDED TO COVER ALL MEDICAL COSTS.

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Signed for Hartford Fire Insurance Company at Hartford, Connecticut



Kevin Barnett, *Secretary*



H. Clay Bassett, JR, *P&C Chief Underwriting Officer*

EXCESS INSURANCE.

Non-Participating

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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; or
7) any other "employee welfare benefit plan" as defined in the Employee Retirement Income Security Act of 1974, as amended.

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

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.

Gainful Occupation means an occupation for which an Insured Person is qualified or may become qualified by reason of education, training or experience, which has a reasonable expectation to provide more than 50% of pre-disability earnings.

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.

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; and
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.

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.

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 31 days advance notice in writing to the Policyholder. Either We or the Policyholder may terminate this Policy on any premium due date by giving 31 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(s) 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. 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;
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) Injury for which the Insured Person is eligible to receive Workers' Compensation benefits or similar benefits, regardless of whether he or she has applied for the benefits;
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;
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) while operating any vehicle or means of Transportation or Conveyance;
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; or
15) injury sustained while playing or practicing in all intercollegiate sports. Any sports activity that is a Covered Activity is not included in this exclusion;
16) 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 90 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 immediately after We receive Proof of Loss. Except for claims for which We are investigating fraud, if We fail to pay a claim within 45 days after we receive Notice of Claim, or otherwise fail to notify the Insured Person in writing specifying the reasons for nonpayment or requesting further documentation, interest on such unpaid benefits will accrue beginning at the end of the 45th day at a rate of one and one-half percent per month, not to exceed eighteen percent per year.

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.

Subrogation
In the event:

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

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

Third Party, as used in this provision, means:

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

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

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

1) a claimant for whom a claim is made examined by a Physician 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
In the absence of fraud, the validity of this Policy shall not be contested, except for nonpayment of premium, after it has been in force for two years from the Policy Effective Date.

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

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

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

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

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

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

Conformity with 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)

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

Policyholder: Bourne Public Schools
Policy Number: 10-BSR-104934

B-61 – Enhanced Accident 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, Inpatient medicines (excluding take home drugs) and Orthopedic Appliances 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) **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.
3) **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.
4) **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.
5) **Physician:** expenses for Treatment provided by a Physician.
6) **Anesthesia:** expenses for pre-operative screening, anesthetics, and administration of anesthesia during a surgical procedure whether on an Inpatient or Outpatient basis.
7) **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.
8) **Blood and Blood Products:** expenses for blood, blood products, artificial blood products, and transfusions of any blood or blood products.
9) **Ambulance:** expenses for ground or air transportation from the emergency site to the Hospital or initial Treatment facility limited to one Ambulance ride per Covered Accident.
10) **Radiological Procedures:** Outpatient expenses for CAT Scan, MRI, X-ray, CT, PET, ultrasound, and other radiological procedures. Does not include dental x-rays.

11) **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.
12) **Prescription Drug - Outpatient:** expenses for drugs prescribed by a Physician for the Treatment of Injury and administered on an Outpatient basis. The Medically Necessary Covered Expense for a prescription drug is limited to the cost of a generic drug unless:
    a) substitution of a generic drug is prohibited by law; or
    b) no generic drug is available; or
    c) the Insured Person's Physician specifically requests that a non-generic drug be dispensed to the Insured Person.
13) **Dental:**
    a) Treatment, repair or replacement of injured natural teeth, includes initial braces when required for Treatment of covered Injury as well as examination, x-rays, restorative Treatment, endodontics, oral surgery, and Treatment for gingivitis resulting from trauma for which pulpal tissues are healthy and intact; and
    b) replacement of caps, crowns, dentures, and orthodontic appliances (including braces), fillings, inlays, crozat appliances, endodontics, oral surgery, examinations and x-ray services as a result of an Injury.
14) **Vision or Hearing Products:** eyeglasses, contact lenses, and hearing aids when damage occurs in a Covered Accident that requires medical Treatment.
15) **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.
16) **Extended Dental Treatment:** expenses for Treatment of an Injury to sound, natural teeth, including examinations, x-rays, endodontics and oral surgery, Bridge or Orthodontics, dental or similar repair (new or replacement) that must be postponed to a date more than 104 weeks after the date of that Injury due to the physiological changes occurring to an Insured Person who is a growing child.

    Such expenses must be incurred on or before the Insured Person's 21st birthday; except that expenses for deferred root canal therapy are covered only if they are incurred within 104 weeks after the date the Injury is sustained.

    Expenses are not covered unless a Physician submits a written certification that the Treatment must be postponed for the reasons stated in the paragraphs above. Such certification must be submitted to Us within 52 weeks after the Injury.
17) **Chiropractic Care**: expenses for Treatment and services received by a chiropractor.
18) **Physical and Occupational Therapy**: expenses for physical or occupational therapy and an office visit connected with any such service.
19) **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.
20) **Motor Vehicle Accident:** expenses for Treatment of an Injury as a result of riding in or driving a motor vehicle.
21) **Hospital Miscellaneous Expenses:** expenses for Inpatient Physiotherapy including expenses for acupuncture; microthermy; manipulation; diathermy; massage therapy; heat Treatment; and ultrasonic Treatment; pre-admission tests and all necessary charges other than room and board, for services received during a Hospital stay.
22) **Outpatient Physiotherapy:** expenses for acupuncture; microthermy; manipulation; diathermy; massage therapy; heat Treatment; and ultrasonic Treatment.

RIDER SCHEDULE

ACCIDENT MEDICAL EXPENSE

Maximum Amount per Insured Person:	$1,000,000
Deductible:	$0 per Covered Accident
Coinsurance:	100% of Usual and Customary Charges
Maximum Benefit Period:	52 weeks from the date of the Covered Accident

Covered Medical Services	**Maximum Amounts Payable**
Hospital:	
Room and Board Expenses:	up to $800 per day Usual and Customary semi-private room rate
Intensive Care Unit:	Usual and Customary Charges not to exceed 7 days
Hospital Miscellaneous Expenses:	up to $800 maximum benefit Usual and Customary Charges
Surgery:	50% Usual and Customary Charges
Assistant Surgeon:	25% of surgical maximum
Anesthesia:	25% of surgical maximum
Outpatient Durable Medical Equipment Rental:	up to $1,000 per Covered Accident Usual and Customary Charges
Radiological Procedures:	up to $800 Usual and Customary Charges per Covered Accident
Outpatient Physiotherapy	$50 per visit maximum 30 visits
Dental:	
For Treatment, repair or replacement of injured natural teeth, includes initial braces when required for Treatment of covered Injury as well as examination, x-rays, restorative Treatment, endodontics, oral surgery, and Treatment for gingivitis resulting from trauma:	up to $750 per tooth Usual and Customary Charges
Replacement of caps, crowns, dentures, and orthodontic appliances (including braces), fillings, inlays, crozat appliances, endodontics, oral surgery, examinations and x-ray services as a result of an Injury:	up to $750 Usual and Customary Charges
Vision or Hearing Products:	up to $650 per Covered Accident Usual and Customary Charges

Extended Dental Treatment:	up to $50,000 per Covered Accident
• Examinations, x-rays, endodontics and oral surgery:	up to $1,000 per tooth Usual and Customary Charges
• Bridge or Orthodontics, dental or similar repair (new or replacement):	up to $1,000 per tooth Usual and Customary Charges
Chiropractic Care:	up to $500 per Covered Accident
Physical and Occupational Therapy:	
• Maximum per Treatment:	Usual and Customary Changes up to $50 limited to one Treatment per day
• Maximum Number of Days:	up to 30 days, limited to one Treatment per day
Motor Vehicle Accident Maximum Benefit Amount	$5,000

SCOPE OF COVERAGE

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

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

LIMITATIONS AND EXCLUSIONS

Rider Exclusions

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

1) intentionally self-inflicted Injury, suicide, or attempted suicide, whether sane or insane;
2) war or act of war, whether declared or undeclared;
3) Injury sustained while in or on, boarding or alighting from, being struck or run down by, any aircraft except as an airline passenger on an aircraft:
    a) operated by a passenger airline on a regularly scheduled trip over its established route or that is chartered by that airline; or
    b) any transport type aircraft operated by the Military Airlift Command (MAC) of the United States or any national government recognized by the United States;
4) Injury for which the Insured Person is eligible to receive Workers' Compensation benefits or similar benefits, regardless of whether he or she has applied for the benefits;
5) Injury sustained or contracted as a consequence of the Insured Person's intoxication or being under the influence of any narcotic unless administered or consumed on the advice of a licensed Physician;
6) Injury sustained by an Insured Person while incarcerated for a felony, except that this exclusion will not be applicable upon acquittal or dismissal of the felony charges;
7) Injury sustained as a result of the Insured Person's being legally intoxicated from the use of alcohol while operating a motor vehicle;
8) Expenses incurred for services, Treatment, supplies or facilities rendered by:
    a) the Policyholder's health service or infirmary; or
    b) any Physician or nurse employed or retained by the Policyholder;
9) pregnancy, childbirth, elective abortion, an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed;
10) Complications of Pregnancy or miscarriage, except as a result of a Covered Accident;
11) elective or cosmetic surgery, except for reconstructive surgery needed as the result of an Injury;
12) expenses paid or payable under any mandatory no fault automobile insurance policy without regard to fault; (This exclusion does not apply in any state where prohibited.);
13) Treatment or service provided by a private duty nurse;
14) routine physical exams and medical services or wellness visits;
15) overuse symptoms including, but not limited to, bursitis, tendonitis, shin splints, stress fractures, heat exhaustion, heat stroke, heat prostration, frostbite, malfunctions of the heart, embolism, reinjuries 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;
16) expenses due to an aggravation or re-Injury of a Pre-existing Condition;
17) expenses incurred that are in excess of Usual and Customary Charges for Covered Medical Services, or expenses that are not covered;
18) Mental and Nervous Disorders;
19) Medical Emergency Evacuation;
20) Experimental or Investigative Treatment or procedures.

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.

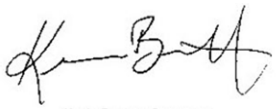
DEFINITIONS

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*



H. Clay Bassett, JR, *P&C Chief Underwriting Officer*