UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • Eatontown, NJ 07724

BLANKET BENEFITS
ACCIDENT ONLY POLICY

Policy Number:	**US151741**
Policyholder:	**School District of Hillsborough County** **P.O. Box 3408** **Tampa, FL 33601**
Policy Effective Date:	**August 1, 2013**
Policy Expiration Date:	**August 1, 2014**

This Policy is issued in the state of Florida and shall be governed by its laws.

This Policy contains the terms under which the Insurance Company agrees to insure certain persons and pay benefits.

The Insurance Company and the Policyholder have agreed to all the terms of this Policy.

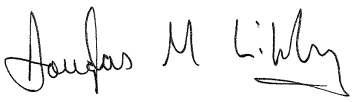
THIS IS AN ACCIDENT ONLY POLICY AND CONTAINS DEDUCTIBLE AND EXCESS INSURANCE PROVISIONS.

PLEASE READ IT CAREFULLY.

BENEFITS ARE NOT PAYABLE FOR LOSS DUE TO SICKNESS.

THIS POLICY PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENT ONLY.

Signed for **The United States Fire Insurance Company** By:



Douglas M. Libby
Chairman and CEO

James Kraus
Secretary

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SCHEDULE OF BENEFITS

BENEFIT PERIOD:	1 Year from the date of an Injury, provided care continues to be Medically Necessary
PREMIUM:	$3.75 (Day Care) $3.50 (Summer) $7.50 (Community Based Trianing)
DEDUCTIBLE AMOUNT:	$0.00
COINSURANCE PERCENTAGE:	100% of Usual, Reasonable & Customary Charges, URC
MAXIMUM BENEFIT AMOUNT:	$25,000.00
Hospital Inpatient Room and Board:	$200.00 Per Day
Hospital Outpatient Expense, Emergency Room:	$185.00 Per Injury
Physician's Expense (Non-Surgical):	$40.00 Per Visit
Physician's Expense (Surgical):	$3,750.00 Per Injury
Diagnostic Imaging:	$400.00 Per Injury
Physiotherapy:	$35.00 Per Visit, 5 Visit Maximum
Prescription Drugs:	$250.00 Per Injury

ELIGIBLE PERSONS: All Students whose names are on file with the Company and are eligible students of the Day Care, Summer and Community Based Training Program of the Policyholder while participating in sponsored and supervised activities.

SPECIFIED ACTIVITY: Day Care, Summer and Community Based Training Programs of the Policyholder.

The Following Benefits Are Provided For <u>ACCIDENTS ONLY</u>:

MEDICAL EXPENSE BENEFIT

Hospital Room & Board Daily Maximum Benefit Amount:	URC
Intensive Care Room & Board Daily Maximum Benefit Amount:	URC
Hospital Miscellaneous Maximum Benefit Amount:	URC
Outpatient Hospital Emergency Room Maximum Benefit Amount:	URC
Outpatient Pre-Admission Testing Benefit Amount:	URC
Surgical Benefits	
Primary Surgeons Maximum Benefit Amount:	URC
Assistant Surgeon, Second Surgical Opinion, Consultation	

Maximum Benefit:	URC
Anesthesia Maximum Benefit Amount:	URC
Surgical Facility Maximum Benefit Amount:	URC
Doctor's Visits	
In-Hospital Maximum Benefit Amount:	URC
Office Visits Maximum Benefit Amount:	URC
Maximum for All In-Hospital and Office Doctor's Visits:	URC
X-ray and Laboratory Maximum Benefit Amount:	URC
Nursing Maximum Benefit Amount:	URC
Physiotherapy Benefit	
Maximum Benefit Amount (hospital inpatient):	URC
Maximum Benefit Amount (outpatient):	URC
Ambulance Maximum Benefit Amount:	URC
Medical Equipment Rental Charges Maximum Benefit Amount:	URC
Medical Services and Supplies Maximum Benefit Amount (Blood, Blood Transfusions, Oxygen)	URC
Dental Treatment Maximum Benefit Amount:	URC
OUT-PATIENT PRESCRIPTION DRUG BENEFIT	
Maximum Benefit Amount:	URC
ACCIDENTAL DEATH, DISMEMBERMENT, LOSS OF SIGHT, SPEECH OR HEARING BENEFIT	
Principal Sum:	$10,000.00

Benefits paid under the policy may be based on Usual, Reasonable and Customary charges. The definition of a Usual, Reasonable and Customary Charge is shown in the DEFINITIONS section.

To determine this charge, we use standard industry databases that calculate the average cost for a given service or supply within the geographical area in which the charge is made. If the actual charge made by the provider is more than the usual, reasonable and customary charge, we will use the usual, reasonable and customary charge amount as a basis of our payment. It is that amount to which we will apply any deductible or coinsurance percentage that may apply. You are then responsible for: (a) the deductible or coinsurance amounts that are applied; (b) any billed amounts above the usual, reasonable of customary charge.

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number:

United States Fire Insurance Company
5 Christopher Way
Eatontown, New Jersey
Phone: 732-918-4747 (collect calls accepted)

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.

"Accident" means an event which is the direct cause, independently of Sickness or Injury that:

(1) Causes Injury to one or more Covered Persons; and

(2) Occurs while coverage is in effect for the Covered Person.

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

"Covered Person" means a person eligible for coverage, for whom proper premium payment has been made, and who is therefore insured under this Policy.

"Deductible Amount" means the amount of Eligible Expenses which must be paid by the Covered Person before benefits are payable under this Policy. It applies separately to each Covered Person.

"Doctor" means a licensed practitioner of the healing arts acting within the scope of his license. Doctor does not include:

(1)The Covered Person;

(2)The Covered Person's Spouse, child, parent, brother, or sister; or

(3) A person living with a Covered Person.

"Eligible Expenses" means the Usual, Reasonable and Customary charges for services or supplies, which are incurred by the Covered Person for the Medically Necessary treatment of Injury. Eligible Expenses must be incurred while this Policy is in force.

"He", "his" and "him" includes "she", "her" and "hers."

"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.

"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 doctors;

(4) Provides 24-hour nursing service by or under the supervision of a graduate registered nurse, (R.N.);

(5) Has on its premises, medical, diagnostic and treatment facilities, including major surgical facilities, available to it on a prearranged basis. A clinic or facility for rehabilitative treatment is a hospital whether or not it includes major surgical facilities; and

(6) Charges for its services.

Hospital does not include:

(1) A clinic or facility for:

(a) Convalescent, custodial, educational or nursing care;

(b) The aged, drug addicts or alcoholics; or

(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.

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

"Insured" means a Covered Person for whom insurance is in force under this Policy.

"Medically Necessary" or "Medical Necessity" means the service or supply is:

(1) Prescribed by a Doctor for the treatment of the Injury; and

(2) Appropriate, according to conventional medical practice for the Injury in the locality in which the service or supply is given.

"Nurse" means either a professional, licensed, graduate registered nurse (R.N.) or a professional, licensed practical nurse (L.P.N.).

"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.

"Sickness" means illness or disease which first manifests itself after coverage is in force under this Policy for the Covered Person. Sickness includes normal pregnancy and complications of pregnancy. All related conditions and recurring symptoms of sickness to the same person will be considered one sickness.

"Supervised or Sponsored Activity" means an authorized function by a Policyholder or School:

(1) In which the Covered Person participates;

(2) Which is organized by or under its auspices; and

(3) Which is within the scope of customary activities for such entity.

"Usual, Reasonable and Customary ("U&C") 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.

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 PROVISIONS**; and results, directly and independently of all other causes, from bodily Injury which is suffered in an Accident; and

(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 Medical Expense

If an Injury to the Covered Person results in his incurring Eligible Expenses for any of the services in the Schedule Of Benefits, we will pay the Eligible Expenses incurred, subject to the Deductible Amount and Coinsurance Percentage (if any), that are in excess of Eligible 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 Doctor when the Eligible Expenses are incurred. The Expense must be incurred solely for the treatment of a covered Injury:

(1) While the person is insured; or

(2) During the Benefit Period stated on the Schedule of Benefits.

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

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

(1) Subject to the specific maximums shown on 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.

PROVISIONS CONCERNING INSUREDS

Eligibility:

Persons eligible to be insured under this Policy are those persons described in an ELIGIBLE CLASS on the Application who have completed any applicable service waiting period. This includes anyone who may become eligible while this Policy is in force.

Effective Dates:

A Covered Person will become an Insured under this Policy, provided proper premium payment is made, on the latest of:

(1) The Policy Effective Date; or

(2) The day he becomes eligible according to the referenced date shown in the Application.

Termination:

Insurance for an Insured will end on the earliest of:

(1) The date he is no longer in an Eligible Class.

(2) The date he 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 Policy expiration date.

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.

DESCRIPTION OF HAZARDS

POLICYHOLDER FUNCTIONS

Subject to all other provisions of this Policy, coverage is provided for a Covered Person while he is:

(1) Attending or participating in a Supervised or Sponsored Activity; or
(2) Attending a Policyholder function.

The Covered Person must be:

(1) On the premises of the Policyholder:
  (a) During its normal hours;
  (b) During scheduled functions; or
  (c) During other periods if he is attending or participating in a Supervised or Sponsored Activity;
(2) Not on Policyholder premises and attending or participating in a Supervised or Sponsored Activity;
(3) Traveling directly, without interruption:
  (a) Between his home and the Policyholder's premises for participation in a Supervised or Sponsored Activity;
  (b) Between the site of the Supervised or Sponsored Activity and his home or the Policyholder's premises.
  (c) In a vehicle which is:
    (i) Designated or furnished by the Policyholder;
    (ii) Operated by a properly licensed adult driver; and
    (iii) Under the direct supervision of the Policyholder; or
  (d) In a vehicle other than that described in (3)(c) when operated by a properly licensed driver.

  "Travel time" includes the time:
    (i) To or from home, the Policyholder's address and the Supervised or Sponsored Activity;
    (ii) Before the appointed time; and
    (iii) After the Supervised or Sponsored Activity is completed.

Unless otherwise stated, we will pay benefits for a covered loss, only once, even if coverage was provided under more than one Description of Hazards.

DESCRIPTION OF BENEFITS

BENEFIT A: ACCIDENTAL DEATH, DISMEMBERMENT, LOSS OF SIGHT, SPEECH OR HEARING BENEFIT

If, within 1-year from the date of an Accident covered by this Policy, Injury from such Accident, results in a loss listed below, 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 Loss as the result of one Accident, We will pay only one amount, the largest to which he is entitled. This amount will not exceed the Principal Sum, shown in the Schedule of Benefits, which applies for the Covered Person.

Loss	Percentage of Principal Sum
Loss of Life	100%
Loss of Both Hands	100%

Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Speech and Hearing (both ears)	100%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%
Loss of Speech	50%
Loss of Hearing (both ears)	50%
Loss of Thumb and Index Finger of the Same Hand	25%

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 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.

MEDICAL EXPENSE BENEFIT

We will pay, Eligible Expenses for a Covered Person's Injury, subject to the Deductible Amount and Coinsurance Percentage, if any, shown in the Schedule of Benefits. Eligible Expenses include:

(1) **Hospital Room and Board** – charges for the most common semi-private daily room rate for each day of the Hospital Stay, up to the Maximum Daily Benefit Amount shown in the Schedule of Benefits for Hospital Room and Board.

(2) **Intensive Care Room and Board** - charges for each day of Intensive Care Unit confinement, up to the Daily Maximum Benefit Amount shown in the Schedule of Benefits for the Intensive Care Room and Board benefit. This payment is in lieu of payment for the Hospital Room and Board charges for those days.

(3) **Hospital Miscellaneous** - charges during a Hospital Stay, up to the Maximum Daily Benefit Amount shown in the Schedule of Benefits for the Hospital Miscellaneous benefit. Miscellaneous charges do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items.

(4) **Outpatient Hospital Expenses** - charges by a Hospital for:
   (a) Pre-admission testing (confinement must occur within 7 days of the testing); or
   (b) Emergency room treatment, up to the Maximum Benefit Amount per emergency shown in the Schedule of Benefits for the Outpatient Emergency Room Treatment benefit.

(5) **Surgical Benefits** - charges for:
   (a) A Doctor, for primary performance of a surgical procedure, up to the Maximum Benefit Amount shown in the Schedule of Benefits per procedure. Two or more surgical procedures through the same incision will

be considered as one procedure. However, we will pay up to 50% of the surgical procedure charge when more than one surgical procedure through different operating fields are performed during the same surgical session.

(b) A Doctor, for: (i) assistant surgeon duties; (ii) a second surgical opinion; or (iii) consultation, up to the Maximum Benefit shown in the Schedule of Benefits for an Assistant Surgeon, Second Surgical Opinion, and Consultation.

(c) Anesthesia and its administration, up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Anesthesia benefit.

(c) Use of surgical facilities, up to the Maximum Benefit Amount per operating session, shown in the Schedule of Benefits for the Surgical Facility benefit.

(6) **Doctor's Visits** - charges by a Doctor for other than pre- or post-operative care:

(a) For in-Hospital visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Doctor's Visit – In-Hospital.

(b) For office visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Doctor's Office Visits.

Total visits per Injury will not exceed the combined Maximum shown in the Schedule of Benefits for All In-Hospital and Office Doctor's Visits.

(7) **X-Ray and Laboratory** - charges for X-ray and laboratory tests, up to the Maximum Benefit Amount shown in the Schedule of Benefits for the X-ray & Laboratory benefit.

(8) **Nursing Services** - Charges for nursing services (other than routine Hospital care) by or under the supervision of a licensed graduate registered nurse, up to the Maximum Benefit Amount shown on the Schedule of Benefits for the Nursing benefit.

(9) **Physiotherapy -** Charges for physiotherapy:

(a) While Hospital confined, up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Hospital Inpatient Physiotherapy benefit;

(b) As an outpatient, up to the Maximum Benefit Amount shown on the Schedule of Benefits for the Outpatient Physiotherapy benefit.

Physiotherapy includes:

(a) Heat treatment;

(b) Diathermy;

(c) Microtherm;

(d) Ultrasonic;

(e) Adjustment;

(f) Manipulation;

(g) Massage therapy and

(h) Acupuncture.

Total treatment per Injury will not exceed the Physiotherapy Maximums shown in the Schedule of Benefits.

(10**)Ambulance** - from the place where the Injury occurred to the Hospital, up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Ambulance benefit.

(11)**Medical Equipment Rental** - charges for medical equipment for:

(a) A wheelchair;

(b) An iron lung; or

(c) Other medical equipment for which prior approval by us has been given;

up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Medical Equipment Rental benefit.

(12)**Medical Services and Supplies** - Charges for medical services and supplies for:

(a) Oxygen and its administration;

(b) Blood and blood transfusions;

up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Medical Service & Supply benefit.

(13)**Dental Treatment** - Charges for dental treatment for Injury to a tooth which was sound and natural at the time of Injury, up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Dental Treatment benefit.

The amounts payable under the Medical Expense Benefit could be greatly reduced if the Covered Person does not comply with the requirements in the Limitations section of this Policy.

OUT-PATIENT PRESCRIPTION DRUG BENEFIT

We will pay the Eligible Expenses, subject to the Deductible Amount and Coinsurance Percentage, if any, for a Prescription Drug or medication when prescribed by a Doctor, on an out-patient basis.

"Prescription Drug" means a drug which:

(1) Under Federal law may only be dispensed by written prescription; and

(2) Is utilized for the specific purpose approved for general use by the Food and Drug Administration.

The Prescription Drug must be dispensed for out-patient use by the Covered Person by a licensed pharmacy provider.

Benefits are payable up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Out-patient Prescription Drug Benefit.

The amount payable under this benefit could be greatly reduced if the Covered Person does not comply with the requirements in the Limitations section of this Policy.

EXCLUSIONS

Benefits will not be paid for a Covered Person's loss which:

(1) Is caused by or results from the Covered Person's own:

(a) Intentionally self-inflicted Injury, suicide or any attempt thereat;

(b) Voluntary self-administration of any drug or chemical substance, not prescribed by, and taken according to the directions of, a doctor (Accidental ingestion of a poisonous substance is not excluded.);

(c) Commission or attempt to commit a felony;

(d) Participation in a riot or insurrection;

(e) Driving under the influence of a controlled substance unless administered on the advice of a Doctor; or

(f) Driving while Intoxicated;

(2) Is caused by or results from:

(a) Declared or undeclared war or act of war;

(b) An Accident, which occurs while the Covered Person is on active duty service in any Armed Forces. (Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 days.);

(c) Aviation, except as specifically provided in this Policy;

(d) 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 and foreseeable result of an accidental external bodily injury or accidental food poisoning.

(e) Nuclear reaction or the release of nuclear energy. However, this exclusion will not apply if the loss is sustained within 180 days of the initial incident and:

(i) The loss was caused by fire, heat, explosion or other physical trauma which was a result of the release of nuclear energy; and

(ii) The Covered Person was within a 25-mile radius of the site of the release either:

1) At the time of the release; or

2) Within 24 hours of the start of the release.

ADDITIONAL EXCLUSIONS

Benefits will not be paid for:

1. Normal health check-ups;
2. Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Covered Person is covered under this Policy, and rendered within 6 months of the Accident;
3. Services or treatment rendered by a Doctor, nurse or any other person who is:
    a. Employed or retained by the Policyholder; or
    b. Who is the Covered Person or a member of his immediate family;
4. Charges which:
    a. The Covered Person would not have to pay if he did not have insurance; or
    b. Are in excess of Usual, Reasonable and Customary charges.
5. An Injury that is caused by flight in:
    a. An aircraft, except as a fare-paying passenger;
    b. A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
    c. An ultra light, hang-gliding, parachuting or bungi-cord jumping;
6. Travel in or upon:
    a. A snowmobile;
    b. Any two or three wheeled motor vehicle;
    c. Any off-road motorized vehicle not requiring licensing as a motor vehicle;
7. 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;
8. That part of medical expense payable by any automobile insurance Policy without regard to fault. (Does not apply in any state where prohibited);
9. Injury that is:
    a. The result of the Covered Person being Intoxicated ; or
    b. Caused by any narcotic, drug, poison, gas or fumes voluntarily taken, administered, absorbed or inhaled, unless prescribed by a Doctor;
10. An Injury resulting from participation in or practice for non-School sponsored skiing, ice hockey, lacrosse, soccer or football;

11. Practice or play in any sports activity, including travel to and from the activity and practice, unless specifically provided for in this Policy;
12. Expenses to the extent that they are paid or payable under other valid and collectible group insurance or medical prepayment plan;
13. Blood or Blood plasma, except for charges by a Hospital for the processing or administration of blood;
14. Elective treatment or surgery, health treatment, or examination where no Injury is involved;
15. 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;
16. Eyeglasses, contact lenses, hearing aids, braces, appliances, or examinations or prescriptions therefore;
17. Treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay;
18. Treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments, or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy;
19. Cosmetic surgery, except for reconstructive surgery due to an Injury;
20. Any loss which is covered and paid by state or federal worker's compensation, employers liability, occupational disease law, or similar laws;
21. The repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices;
22. Rest cures or custodial care;
23. The repair or replacement of existing dentures, partial dentures, braces or fixed or removable bridges;
24. Expenses incurred after the Benefit Period, except as shown in the Schedule of Benefits;
25. Orthopedic appliances, which are used mainly to protect an Injury so that a covered student can take part in interscholastic or intercollegiate sports;
26. Services and supplies furnished by the School infirmary, its employees, or Doctor who works for the School;
27. Hernia of any kind;
28. Prescription medicines unless specifically provided for under this Policy.

LIMITATIONS

Any benefits payable under this Policy will be limited to the following:

(1) The medical benefits otherwise payable under this Policy will be reduced by 50% if:
   (a) Excess insurance is provided under this Policy; and
   (b) The Covered Person has coverage under another plan providing medical expense benefits; and
   (c) The other plan is an HMO, PPO or similar arrangement ("PPO-Preferred Provider Organization" means an Organization offering health care services through designated health care providers who agree to perform these services at rates lower than non-preferred providers.); and
   (d) The Covered Person does not use the facilities or services of the HMO, PPO or similar arrangement for the provision of benefits.

The Covered Person's limitation does not apply to emergency treatment required within 24 hours after an Accident, which occurred outside the geographic area serviced by the HMO, PPO or similar arrangement.

(2) Costs that exceed the Usual, Reasonable and Customary charges in the area where the services are furnished or supplies provided. Services, supplies and equipment must be:
   a) Medically necessary for the care or treatment of a covered Injury;

b) Received while coverage is in force under this Policy; and

c) Rendered and/or prescribed by a licensed Doctor other than the Covered Person (or a member of his household or immediate family) in accordance with current medical standards and practices.

(3) The application of the Coordination of Benefits or Non-Duplication of Benefits provision.

(4) If the Covered Person is admitted into the Hospital on a Friday or a Saturday on a non-emergency basis and the procedure for which he is admitted is not performed on the day of or the day after admission, we will not pay the Hospital charges for room and board or miscellaneous Hospital charges for the initial Friday or Saturday preceding the procedure.

PREMIUM PROVISIONS

GRACE PERIOD:

A grace period of not less than 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.

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 Policyholder's most recent address in our records.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES:

This Policy, the application of the Policyholder (a copy of which is attached), endorsements, riders and attached papers constitute the entire contract between the parties. If an application of an Insured is required, the application of any Insured, at our option, may also be made a part of this contract.

All statements made by the Policyholder 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 his death or incapacity, his beneficiary or representative. After two 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.

No change in this Policy will be valid until approved by one of our executive officers. This approval must be endorsed on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

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 Policyholder may terminate its coverage on any premium due date. Written notice must be given at least 45 days prior to such premium due date. Failure by the Policyholder 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. Termination of coverage will not affect a claim for an Insured that occurs either before or after such termination if that loss results from an Accident that occurred while the Insured's coverage was in force.

CONFORMITY WITH STATE STATUTES:

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

CLAIM PROVISIONS

NOTICE OF CLAIM:

Written notice must be given to us within 30 days after a covered loss occurs or begins or as soon as reasonably possible. Notice can be given at our administrative office at Irving, Texas or to our agent. Notice should include the Policyholder's name and number and the Insured'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 one 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:

Benefits for the Insured'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 the Insured's written request, in accordance with one of our settlement plans. If the Insured has not requested any settlement plan, the beneficiary can do so in writing after the Insured's death. If there is no named beneficiary or surviving beneficiary, the Insured'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 the Insured's proceeds;
(2) Spouse;
(3) Child or children;
(4) Mother or father;
(5) Sisters or brothers; or
(6) The estate; of the Insured.

If we are to pay benefits to the estate or to a person who is incapable of giving a valid release, 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 he is living, if not, we will pay his beneficiary or his estate.

CHANGE OF BENEFICIARY:

The Insured 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 the Insured 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.

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 after the expiration of the applicable statute of limitations from the time written proof of loss is required to be furnished.

CONDITIONAL CLAIM PAYMENT:

If a Covered Person incurs expenses for Injuries received in a covered Accident, and in our opinion a third party may be liable, we will pay benefits if:

(1) The Covered Person first agrees in writing to refund the lesser of:
   (a) The amount we actually paid for such expenses; or
   (b) The amount actually received from the third party for such expenses; and
(2) The third party's liability is determined and satisfied whether by settlement, judgment, arbitration or otherwise.

However, prior to our payment of benefits under this Policy, if the third party's liability is satisfied in an amount less than the benefits payable under this Policy, we will pay the difference.

RECOVERY OF BENEFITS:

We reserve the right to recover from a Covered Person any benefits we have paid to him 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 he gives us proof such benefits have been denied to him.

SUBROGATION:

If we have paid benefits to a Covered Person for Injuries received in a covered Accident, and in Our opinion 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 his rights to Us. We will exercise such rights on his behalf. He further agrees to furnish Us with all relevant information and documents.

When used throughout this document “The Company”, “Our”, “We”, or “Us” means:

United States Fire Insurance Company

PRIVACY POLICY AND PRACTICES

The Company values your business and your trust. In order to administer insurance policies and provide you with effective customer service, we must collect certain information about our customers. We want you to know that we are committed to protecting your private information and we will comply with all federal and state privacy laws. Below is a Privacy Notice describing our policy regarding the collection and disclosure of personal information. Please review this Notice and keep a copy of it with your records.

Your Privacy is Our Concern

When you apply to The Company for insurance or make a claim against a policy written by The Company, you disclose information about yourself to us. There are legal requirements governing the collection, use, and disclosure of such information. The Company maintains physical, electronic, and procedural safeguards that comply with state and federal regulations to guard your personal information. We also limit employee access to personally identifiable information to those with a business reason for knowing such information. The Company instructs our employees as to the importance of the confidentiality of personal information, and takes measures to enforce employee privacy responsibilities.

What kind of information do we collect about you and from whom?

We obtain most of our information from you. The application or claim form you complete, as well as any additional information you provide, generally gives us most of the information we need to know. Sometimes we may contact you by phone or mail to obtain additional information. We may use information about you from other transactions with us, our affiliates, or others. Depending on the nature of your insurance transaction, we may need additional information about you or other individuals proposed for coverage. We may obtain the additional information we need from third parties, such as other insurance companies or agents, government agencies, medical personnel, the state motor vehicle department, information clearinghouses, credit reporting agencies, courts, or public records. A report from a consumer reporting agency may contain information as to creditworthiness, credit standing, credit capacity, character, general reputation, hobbies, occupation, personal characteristics, or mode of living.

What do we do with the information collected about you?

If coverage is declined or the charge for coverage is increased because of information contained in a consumer report we obtained, we will inform you, as required by state law or the federal Fair Credit Reporting Act. We will also give you the name and address of the consumer reporting agency making the report. We may retain information about our former customers and may disclose that information to affiliates and non-affiliates only as described in this notice.

To whom do we disclose information about you?

We may disclose all the information that we collect about you, as described above. We may disclose such information about you to our affiliated companies, such as:

- Insurance companies;
- Insurance agencies;
- Third party administrators;
- Medical bill review companies; and
- Reinsurance companies.

We may also disclose nonpublic personal information about you to affiliated and nonaffiliated third parties as permitted by law. You have a right to access and correct the personal information we collect, maintain, and disclose about you.

How to contact Us

You may obtain a more detailed description of the information practices prescribed by law by contacting us at the address below. Remember to include your name, address, policy number, and daytime phone number.

Privacy Policy Coordinator

Fairmont Speciality
5 Christopher Way, 3rd Floor
Eatontown, New Jersey 07724

When used throughout this document "Company", "Our", "We", or "Us" means:

United States Fire Insurance Company

GRIEVANCE PROCEDURES

When you submit a claim and that claim is denied, we will provide a written statement containing the reasons for the Adverse Determination. You have the right to request a review of any Company decision or action pertaining to our contractual relationship and to appeal any adverse claim determination we've made by filing a Grievance. These procedures have been developed to ensure a full investigation of a Grievance through a formal process.

DEFINITIONS

A **"Grievance"** is a written complaint requesting a change to a previous claim decision, claims payment, the handling or reimbursement of health care services, or other matters pertaining to your coverage and our contractual relationship.

An **"Adverse Determination"** is a determination by the Company or its designated utilization review organization that (i) a service, treatment, drug, or device, is experimental, investigational, specifically limited or excluded by your coverage; or (ii) a facility admission, the availability of care, continued stay or other health care services proposed or furnished have been reviewed and, based upon the information provided, does not meet the contractual requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and therefore, the benefit coverage is denied, reduced or terminated in whole or in part.

INFORMAL GRIEVANCE PROCEDURE

You, your authorized representative, or a provider acting on your behalf may submit an oral complaint to us within 60-days after an event that causes a dispute. Telephoning allows you to discuss your complaint or concerns and gives us the opportunity to immediately resolve the problem.

If we don't have all the information necessary to review your complaint, we will request any additional information within 5 business days of receiving your complaint. After we receive all the necessary information, we will provide you, your authorized representative, or a provider acting on your behalf with our written decision within 30-days after receiving the complaint and all necessary information.

If the problem cannot be resolved in this manner, you still have the right to submit a written request for the complaint to be reviewed through the Formal Grievance Procedure, as outlined below.

FORMAL GRIEVANCE PROCEDURE

A formal Grievance may be submitted by you, your authorized representative, or in the event of an Adverse Determination, by a provider acting on your behalf.

If you file a formal Grievance, you will have the opportunity to submit written comments, documents, records and other information you feel are relevant to the Grievance, regardless of whether those materials were considered in the initial Adverse Determination.

First Level Review

Within 3 working business days after receiving the Grievance, we must acknowledge the Grievance and provide you, your authorized representative or a provider with the name, address, and telephone number of the coordinator handling the Grievance and information on how to submit written material. The person(s) who reviews the Grievance will not be the same person(s) who made the initial Adverse Determination. During the review, all information, documents, and other materials submitted relating to the claim will be considered, regardless of whether they were considered in making the previous claim decision. The Insured will not be allowed to attend, or have a representative attend, a First Level Review. The Insured may, however, submit written material for consideration by the reviewer(s).

When the Grievance is based in whole or in part on a medical judgment, the review will be conducted by, or in consultation with, a medical doctor with appropriate training and expertise to evaluate the matter.
Following our review of your Grievance, we must issue a written decision to you and, if applicable, to your representative or provider, within 20-days after receiving the Grievance. The written decision must include:

(1) The name(s), title(s) and professional qualifications of any person(s) participating in the First Level Review process.

(2) A statement of the reviewer's understanding of the Grievance.

(3) The specific reason(s) for the reviewer's decision in clear terms and the contractual basis or medical rationale used as the basis for the decision in sufficient detail for the Insured to respond further to our position.

(4) A reference to the evidence or documentation used as the basis for the decision.

(5) If the claim denial is based on medical necessity, experimental treatment or similar exclusion, instructions for requesting an explanation of the scientific or clinical rationale used to make the determination.

(6) A statement advising you of your right to request a Second Level Review, if applicable, and a description of the procedure and timeframes for requesting a Second Level Review.

Second Level Review

The Second Level Review process is available if you are not satisfied with the outcome of the First level Review for an Adverse Determination. Within ten business days after receiving a request for a Second Level Review, we will advise you of the following:

(1) the name, address, and telephone number of a person designated to coordinate the Grievance review for the Company;
(2) a statement of your rights, including the right to:
- attend the Second Level Review
- present his/her case to the review panel;
- submit supporting materials before and at the review meeting;
- ask questions of any member of the review panel;
- be assisted or represented by a person of his/her choice, including a provider, family member, employer representative, or attorney.
- request and receive from us free of charge, copies of all relevant documents, records and other information that is not confidential or privileged that were considered in making the Adverse Determination.

We must convene a review panel and hold a review meeting within 45-days after receiving a request for a Second Level Review. We will notify you in writing of the meeting date at least 15-days prior to the date. The review meeting will be held during regular business hours at a location reasonable accessible to you. In cases where a face-to-face meeting is not practical for geographic reasons, we will offer you the opportunity to communicate with the review panel at our expense by conference call or other appropriate technology. Your right to a full review may not be conditioned on whether or not you appear at the meeting.

If you choose to be represented by an attorney, we may also be represented by an attorney. If we choose to have an attorney present to represent our interests, we will notify you at least 15 working days in advance of the review that an attorney will be present and that you may wish to obtain legal representation of your own.

The panel must be comprised of persons who:

(1) were not previously involved in any matter giving rise to the Second Level Review;
(2) are not employees of the Company or Utilization Review Organization; and
(3) do not have a financial interest in the outcome of the review.

A person previously involved in the Grievance may appear before the panel to present information or answer questions.

All persons reviewing a Second Level Grievance involving a Utilization Review non-certification or a clinical issue will be providers who have appropriate expertise, including at least one clinical peer. If we use a clinical peer on an appeal of a Utilization Review non-certification or on a First Level Review, we may use one of our employees on the Second Level Review panel if the panel is comprised of 3 or more persons.

We must issue a written decision to you and, if applicable, to your representative or provider, within 10 business days after completing the review meeting. The decision must include:

(1) the name(s), title(s) and qualifying credentials of the members of the review panel;
(2) a statement of the review panel's understanding of the nature of the Grievance and all pertinent facts;
(3) the review panel's recommendation to the Company and the rationale behind the recommendation;
(4) a description of, or reference to, the evidence or documentation considered by the review panel in making the recommendation;
(5) in the review of a Utilization Review non-certification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the determination;
(6) the rationale for the Company's decision if it differs from the review panel's recommendation;
(7) a statement that the decision is the Company's final determination in the matter;
(8) notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

EXPEDITED REVIEW

You are eligible for an expedited review when the timeframes for an Informal, formal First Level review or Second Level review would reasonably appear to seriously jeopardize your life or health, or your ability to regain maximum function. An expedited review is also available for all Grievances concerning an admission, availability of care, continued stay or health care service for a person who has received emergency services, but who has not been discharged from a facility.

A request for an expedited review may be submitted orally or in writing. An expedited review must be evaluated by an appropriate clinical peer in the same or similar specialty as would typically manage the case being reviewed. If we don't have the information necessary to decide an appeal, we will send you notification of precisely what is required within 24-hours of our receipt of your Grievance. All necessary information, including our decision, will be transmitted by telephone, facsimile, or the most expeditious method available. Provided we have enough information to make a decision, you, your authorized representative, or a provider acting on your behalf will be notified of the determination as expeditiously as the medical condition requires, but in no event more than 72-hours after the review has commenced. Written confirmation of our decision will be provided within 2 working business days of the decision and will contain the same items described in the written decision requirements for First Level reviews.

If the expedited review does not resolve the situation, you, your representative or a provider acting on your behalf may submit a written Grievance.

We will not provide an expedited review for retrospective reviews of Adverse Determinations.