



(Herein, "We," "Us," "Our" or the Company)

Hereby issues to the School this Policy insuring the persons of the School, herein called the Insured. The Company agrees to pay the described benefits in this Policy. Coverage is subject to provisions for Injuries received while the Insured is:

- (a) participating in or attending any School Sponsored and Supervised Activity. The activity must be supervised by an authorized representative of the School;
- (b) traveling directly and uninterruptedly to and from such School Sponsored and Supervised Activity with other members as a group. Such travel must be supervised by an authorized representative of the School;
- (c) traveling directly and uninterruptedly to or from the Insured's Residence and the meeting place for the purpose of participating in a School Sponsored and Supervised Activity.

Further, in consideration of payment of the premium for 24-Hour Coverage, this insuring clause is amended to include the following:

- (d) engaged in activities other than those named in paragraphs (a) through (c) above, except for those activities specifically excluded by this Policy or by any endorsements.

ALL BENEFITS AND EXCLUSIONS ARE DESCRIBED HEREIN.

This Policy is issued in consideration of (a) the attached application made a part hereof; and (b) payment of premium as set forth.

Signed for the Company at its Home Office, Cedar Rapids, Iowa.

NON-PARTICIPATING  
BLANKET STUDENT ACCIDENT ONLY POLICY

**MONUMENTAL LIFE INSURANCE COMPANY**  
Cedar Rapids, Iowa

A handwritten signature in cursive script that reads "Stacy Boyer".

**Secretary**

A handwritten signature in cursive script that reads "Brenda Casey".

**President**

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**SCHEDULE OF BENEFITS**

POLICYHOLDER: Oxford Public Schools

POLICY NUMBER: C072

EFFECTIVE DATE: July 1, 2014

TERMINATION DATE: June 30, 2015

APPLIES TO:

Voluntary participation school time and 24-hour plans excluding all interscholastic sports.

Maximum Medical Expense Benefit for each Injury: \$500,000

Benefit Period:

**\$500,000 MAXIMUM MEDICAL EXPENSE BENEFIT WITH A 5 YEAR BENEFIT PERIOD UNDER VOLUNTARY STUDENT PLAN**

Coverage will be provided only for the benefits specified below.

**STUDENT ACCIDENT ONLY SCHEDULE OF BENEFITS:**

**BENEFITS FOR HOSPITAL AND PROFESSIONAL SERVICES:**

Initial treatment must be rendered within 60 days of the date of Injury, otherwise no benefits are payable.

Services must be rendered within 5 year(s) from the date of Injury. Expenses incurred after 5 year(s) from the date of Injury are not covered even though the service is a continuing one or one that is necessarily delayed beyond 5 year(s) from the date of the Injury.

Benefits will be paid up to a maximum of \$500,000 for any one Injury, which are in excess of the deductible.

The Deductible Amount is the greater of:

- 1. \$0; or
- 2. Benefits paid for the same Injury under all Other Valid and Collectible Health Insurance Plans.

EXCESS PROVISION: Non-excess.

**HOSPITAL AND PROFESSIONAL SERVICES BENEFIT**

Maximum Benefit Limitations:

**1. DENTAL:**

Usual and Customary Charge up to a maximum of \$10,000 per Accident. This covers treatment of sound and natural teeth as well as capped or crowned teeth.

2. **EYEGASSES CONTACTS LENSES AND HEARING AIDS:**  
Usual and Customary Charge up to \$500 per Accident maximum is allowed for replacement of eyeglasses, contact lenses, or hearing aids broken or damaged in a covered Accident in which medical treatment is provided for accidental bodily Injury.
3. **HOSPITAL:**  
Hospital room and board is covered at the semi-private room rate up to the Usual and Customary Charge per day and Usual and Customary Charge for inpatient miscellaneous (inpatient or as outpatient for day surgery) expenses are covered.
4. **HOSPITAL EMERGENCY ROOM:**  
Usual and Customary Charge for treatment within 72 hours of an Injury (including supplies and services except x-rays).
5. **NURSING SERVICES:**  
Usual and Customary Charge, if prescribed by a Physician and the Insured is, Hospital confined.
6. **ORTHOPEDIC BRACES & APPLIANCES:**  
Usual and Customary Charge.
7. **OUTPATIENT SERVICES AND LABORATORY TESTS:**  
Usual and Customary Charge.
8. **PHYSICIAN'S VISITS:**  
Usual and Customary Charge for non-surgical doctor visits (including office visits) will be paid.
9. **PHYSICAL THERAPY AND/OR SPINAL MANIPULATION:**  
Usual and Customary Charge for in hospital diathermy, heat treatment, adjustment, manipulation or massage is covered.
10. **PRESCRIPTION DRUGS:**  
Prescription drugs are covered up to the Usual and Customary Charge when prescribed by a Physician for treatment of a covered Accident.
11. **SECOND OPINION:**  
Usual and Customary Charge is allowed for consultations and second opinions, in cases in which surgery is contemplated.
12. **SURGERY AND ANESTHESIA:**  
**SURGERY** - Usual and Customary Charge is allowed.  
  
**ANESTHESIA** - Usual and Customary Charge is allowed.
13. **X-RAYS AND DIAGNOSTIC IMAGING:**  
Usual and Customary Charge when billed by provider other than a Hospital.
14. **HYPODERMIC NEEDLES OR SYRINGES:**  
As prescribed by a Physician to administer covered medications.

## SCHEDULE OF BENEFITS

POLICYHOLDER: Oxford Public Schools

POLICY NUMBER: C072

EFFECTIVE DATE: July 1, 2014

TERMINATION DATE: June 30, 2015

### APPLIES TO:

Senior High School Interscholastic Sports including tackle football; Junior high school sports; band, cheerleaders, majorettes; intramural sports; non-sport extra-curricular activities.

Maximum Medical Expense Benefit for each Injury: \$5,000,000

### Benefit Period:

UP TO \$5,000,000 MAXIMUM BENEFIT WITH A 10 YEAR BENEFIT PERIOD UNDER COMPULSORY ATHLETIC PLAN

Coverage will be provided only for the benefits specified below.

### STUDENT ACCIDENT ONLY SCHEDULE OF BENEFITS:

#### BENEFITS FOR HOSPITAL AND PROFESSIONAL SERVICES:

Initial treatment must be rendered within 60 days of the date of Injury, otherwise no benefits are payable.

Services must be rendered within **10** year(s) from the date of Injury. Expenses incurred after **10** year(s) from the date of Injury are not covered even though the service is a continuing one or one that is necessarily delayed beyond **10** year(s) from the date of the Injury.

Benefits will be paid up to a maximum of \$5,000,000 for any one Injury, which are in excess of the deductible.

The Deductible Amount is the greater of:

1. \$0; or
2. Benefits paid for the same Injury under all Other Valid and Collectible Health Insurance Plans.

EXCESS PROVISION: This provision is described in the Student Accident Only Benefits section.

This provision will only apply when there is no identifiable charge, to the parent or student, for coverage.

### HOSPITAL AND PROFESSIONAL SERVICES BENEFIT

Maximum Benefit Limitations:

#### 1. **DENTAL:**

Usual and Customary Charge up to a maximum of \$10,000 per Accident. This covers treatment of sound and natural teeth as well as capped or crowned teeth for up to 260 weeks from the date of Injury.

2. **EYEGASSES CONTACTS LENSES AND HEARING AIDS:**  
Usual and Customary Charge up to \$500 per Accident maximum is allowed for replacement of eyeglasses, contact lenses, or hearing aids broken or damaged in a covered Accident in which medical treatment is provided for accidental bodily Injury.
3. **HOSPITAL:**  
Hospital room and board is covered at the semi-private room rate up to the Usual and Customary Charge per day and Usual and Customary Charge for inpatient miscellaneous (inpatient or as outpatient for day surgery) expenses are covered.
4. **HOSPITAL EMERGENCY ROOM:**  
Usual and Customary Charge for treatment within 72 hours of an Injury (including supplies and services except x-rays).
5. **NURSING SERVICES:**  
Usual and Customary Charge, if prescribed by a Physician and the Insured is, Hospital confined.
6. **ORTHOPEDIC BRACES & APPLIANCES:**  
Usual and Customary Charge.
7. **OUTPATIENT SERVICES AND LABORATORY TESTS:**  
Usual and Customary Charge.
8. **PHYSICIAN'S VISITS:**  
Usual and Customary Charge for non-surgical doctor visits (including office visits) will be paid.
9. **PHYSIOTHERAPY:**  
Usual and Customary Charge for in hospital diathermy, heat treatment, adjustment, manipulation or massage is covered. Coverage is also provided for necessary treatment in the doctor's office, or by a Sports Medicine Center or similar facility up to the Usual and Customary Charge, provided the treatment is rendered by a licensed Physician or registered physical therapist.
10. **PRESCRIPTION DRUGS:**  
Prescription drugs are covered up to the Usual and Customary Charge when prescribed by a Physician for treatment of a covered Accident.
11. **SECOND OPINION:**  
Usual and Customary Charge is allowed for consultations and second opinions, in cases in which surgery is contemplated.
12. **SURGERY AND ANESTHESIA:**  
**SURGERY** - Usual and Customary Charge is allowed.  
**ANESTHESIA** - Usual and Customary Charge is allowed.
13. **X-RAYS AND DIAGNOSTIC IMAGING:**  
Usual and Customary Charge when billed by provider other than a Hospital.
14. **HYPODERMIC NEEDLES OR SYRINGES:**  
As prescribed by a Physician to administer covered medications.

## SCHEDULE OF BENEFITS

POLICYHOLDER: Oxford Public Schools

POLICY NUMBER: C072

EFFECTIVE DATE: July 1, 2014

TERMINATION DATE: June 30, 2015

APPLIES TO:  
Gym classes.

Maximum Medical Expense Benefit for each Injury: \$5,000,000

Benefit Period:  
UP TO \$5,000,000 MAXIMUM BENEFIT WITH A 10 YEAR BENEFIT PERIOD UNDER COMPULSORY ATHLETIC PLAN

Coverage will be provided only for the benefits specified below.

### STUDENT ACCIDENT ONLY SCHEDULE OF BENEFITS:

#### BENEFITS FOR HOSPITAL AND PROFESSIONAL SERVICES:

Initial treatment must be rendered within 60 days of the date of Injury, otherwise no benefits are payable.

Services must be rendered within **10** year(s) from the date of Injury. Expenses incurred after **10** year(s) from the date of Injury are not covered even though the service is a continuing one or one that is necessarily delayed beyond **10** year(s) from the date of the Injury.

Benefits will be paid up to a maximum of \$5,000,000 for any one Injury, which are in excess of the deductible.

The Deductible Amount is:

1. \$25,0000;
2. Benefits paid for the same Injury under all Other Valid and Collectible Health Insurance Plans.

EXCESS PROVISION: This provision is described in the Student Accident Only Benefits section.

This provision will only apply when there is no identifiable charge, to the parent or student, for coverage.

### HOSPITAL AND PROFESSIONAL SERVICES BENEFIT

Maximum Benefit Limitations:

1. **DENTAL:**

Usual and Customary Charge up to a maximum of \$10,000 per Accident. This covers treatment of sound and natural teeth as well as capped or crowned teeth for up to 260 weeks from the date of Injury.

2. **EYEGASSES CONTACTS LENSES AND HEARING AIDS:**  
Usual and Customary Charge up to \$500 per Accident maximum is allowed for replacement of eyeglasses, contact lenses, or hearing aids broken or damaged in a covered Accident in which medical treatment is provided for accidental bodily Injury.
3. **HOSPITAL:**  
Hospital room and board is covered at the semi-private room rate up to the Usual and Customary Charge per day and Usual and Customary Charge for inpatient miscellaneous (inpatient or as outpatient for day surgery) expenses are covered.
4. **HOSPITAL EMERGENCY ROOM:**  
Usual and Customary Charge for treatment within 72 hours of an Injury (including supplies and services except x-rays).
5. **NURSING SERVICES:**  
Usual and Customary Charge, if prescribed by a Physician and the Insured is, Hospital confined.
6. **ORTHOPEDIC BRACES & APPLIANCES:**  
Usual and Customary Charge.
7. **OUTPATIENT SERVICES AND LABORATORY TESTS:**  
Usual and Customary Charge.
8. **PHYSICIAN'S VISITS:**  
Usual and Customary Charge for non-surgical doctor visits (including office visits) will be paid.
9. **PHYSIOTHERAPY:**  
Usual and Customary Charge for in hospital diathermy, heat treatment, adjustment, manipulation or massage is covered. Coverage is also provided for necessary treatment in the doctor's office, or by a Sports Medicine Center or similar facility up to the Usual and Customary Charge, provided the treatment is rendered by a licensed Physician or registered physical therapist.
10. **PRESCRIPTION DRUGS:**  
Prescription drugs are covered up to the Usual and Customary Charge when prescribed by a Physician for treatment of a covered Accident.
11. **SECOND OPINION:**  
Usual and Customary Charge is allowed for consultations and second opinions, in cases in which surgery is contemplated.
12. **SURGERY AND ANESTHESIA:**  
**SURGERY** - Usual and Customary Charge is allowed.  
**ANESTHESIA** - Usual and Customary Charge is allowed.
13. **X-RAYS AND DIAGNOSTIC IMAGING:**  
Usual and Customary Charge when billed by provider other than a Hospital.
14. **HYPODERMIC NEEDLES OR SYRINGES:**  
As prescribed by a Physician to administer covered medications.



## SCHEDULE OF BENEFITS

POLICYHOLDER: Oxford Public Schools

POLICY NUMBER: C072

EFFECTIVE DATE: July 1, 2014

TERMINATION DATE: June 30, 2015

APPLIES TO:  
Field trips.

Maximum Medical Expense Benefit for each Injury: \$10,000

Benefit Period:  
UP TO \$10,000 MAXIMUM BENEFIT WITH A 10 YEAR BENEFIT PERIOD UNDER COMPULSORY STUDENT PLAN

Coverage will be provided only for the benefits specified below.

### STUDENT ACCIDENT ONLY SCHEDULE OF BENEFITS:

#### BENEFITS FOR HOSPITAL AND PROFESSIONAL SERVICES:

Initial treatment must be rendered within 60 days of the date of Injury, otherwise no benefits are payable.

Services must be rendered within **10** year(s) from the date of Injury. Expenses incurred after **10** year(s) from the date of Injury are not covered even though the service is a continuing one or one that is necessarily delayed beyond **10** year(s) from the date of the Injury.

Benefits will be paid up to a maximum of \$10,000 for any one Injury, which are in excess of the deductible.

The Deductible Amount is the greater of:

1. \$0; or
2. Benefits paid for the same Injury under all Other Valid and Collectible Health Insurance Plans.

EXCESS PROVISION: This provision is described in the Student Accident Only Benefits section.

This provision will only apply when there is no identifiable charge, to the parent or student, for coverage.

### HOSPITAL AND PROFESSIONAL SERVICES BENEFIT

Maximum Benefit Limitations:

1. **DENTAL:**

Usual and Customary Charge up to a maximum of \$10,000 per Accident. This covers treatment of sound and natural teeth as well as capped or crowned teeth for up to 260 weeks from the date of Injury.

2. **EYEGASSES CONTACTS LENSES AND HEARING AIDS:**  
Usual and Customary Charge up to \$500 per Accident maximum is allowed for replacement of eyeglasses, contact lenses, or hearing aids broken or damaged in a covered Accident in which medical treatment is provided for accidental bodily Injury.
3. **HOSPITAL:**  
Hospital room and board is covered at the semi-private room rate up to the Usual and Customary Charge per day and Usual and Customary Charge for inpatient miscellaneous (inpatient or as outpatient for day surgery) expenses are covered.
4. **HOSPITAL EMERGENCY ROOM:**  
Usual and Customary Charge for treatment within 72 hours of an Injury (including supplies and services except x-rays).
5. **NURSING SERVICES:**  
Usual and Customary Charge, if prescribed by a Physician and the Insured is, Hospital confined.
6. **ORTHOPEDIC BRACES & APPLIANCES:**  
Usual and Customary Charge.
7. **OUTPATIENT SERVICES AND LABORATORY TESTS:**  
Usual and Customary Charge.
8. **PHYSICIAN'S VISITS:**  
Usual and Customary Charge for non-surgical doctor visits (including office visits) will be paid.
9. **PHYSIOTHERAPY:**  
Usual and Customary Charge for in hospital diathermy, heat treatment, adjustment, manipulation or massage is covered. Coverage is also provided for necessary treatment in the doctor's office, or by a Sports Medicine Center or similar facility up to the Usual and Customary Charge, provided the treatment is rendered by a licensed Physician or registered physical therapist.
10. **PRESCRIPTION DRUGS:**  
Prescription drugs are covered up to the Usual and Customary Charge when prescribed by a Physician for treatment of a covered Accident.
11. **SECOND OPINION:**  
Usual and Customary Charge is allowed for consultations and second opinions, in cases in which surgery is contemplated.
12. **SURGERY AND ANESTHESIA:**  
**SURGERY** - Usual and Customary Charge is allowed.  
**ANESTHESIA** - Usual and Customary Charge is allowed.
13. **X-RAYS AND DIAGNOSTIC IMAGING:**  
Usual and Customary Charge when billed by provider other than a Hospital.
14. **HYPODERMIC NEEDLES OR SYRINGES:**  
As prescribed by a Physician to administer covered medications.

**ACCIDENTAL DEATH, DISMEMBERMENT, AND LOSS OF SIGHT BENEFIT:**

\$10,000 will be paid (as shown in the following schedule) if death occurs within 100 days of the date of Accident.

\$20,000 will be paid (as shown in the following schedule) for dismemberment occurring within 100 days of the date of Accident.

Loss of Life:	\$10,000
Loss of Both Hands, Both Feet, or Sight of Both Eyes:	\$20,000
Loss of One Hand, One Foot, or Sight of One Eye:	\$15,000

**VOLUNTARY PARTICIPATION DENTAL COVERAGE BENEFIT**

Usual and Customary Charge up to a maximum of \$5,000, per Accident, subject to the following: \$5,000 for each treatment and service, of sound natural teeth; \$500 maximum for treatment for dentures, braces, caps, crowns, fillings, bridges, prosthetic, or orthodontic devices or any artificial dental device. Treatment must be rendered within 52 weeks of the Injury.

**STUDENT DISABILITY BENEFIT**

After 6 months of an eligible Disability an initial Disability benefit of \$50,000 will be paid. Thereafter, a monthly benefit of \$1,000 until age 65 or up to a maximum benefit of \$550,000, whichever occurs first.

**MANDATED BENEFITS**

**ACCIDENTAL INGESTION OR CONSUMPTION OF A CONTROLLED DRUG**

Inpatient ..... Maximum 30 days per Calendar Year  
Outpatient ..... Maximum of \$500 per Calendar Year

**AMBULANCE:**

Ambulance Services Benefit ..... Usual and Customary Charge

**HOME HEALTH CARE**

After \$50.00 deductible, Usual and Customary Charge for eligible charges up to the overall Policy maximum.

**DEFINITIONS**

**ACCIDENT** means an unexpected or unforeseen occurrence, which results in an Injury and occurs while the Insured is covered under this Policy.

**ACTUAL CHARGE** means the fee charged by the Physician or Hospital for a covered service.

**DEDUCTIBLE** means the dollar amount of Covered Medical Expenses and Covered Dental Expenses which must be incurred as an out-of-pocket expense, by an Insured for each Loss, before benefits are payable under this Policy. The Deductible amount is shown on the Schedule.

**HOSPITAL** means a duly licensed institution which: (1) accommodates a minimum of 5 resident bed patients; (2) contains diagnostic, laboratory and surgical facilities where major surgery is performed; (3) provides continuous services by registered nurses; and (4) at which a Doctor of Medicine or Osteopathy is in regular attendance.

A Hospital is not other than incidentally: (1) a convalescent home, or (2) a rest or nursing home.

**IMMEDIATE FAMILY MEMBER** means a person who is related to the Insured in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild).

**INJURY** means bodily injury caused by an Accident. The injury must occur while this Policy is in force and while the Insured is covered under this Policy. The injury must be sustained while the Insured is participating in an activity covered by this Policy.

The term injury also means the treatment of a re-injury, incurred while this Policy is in force with respect to the Insured, for which the Insured has been treatment free for a period of at least **180** days prior to the effective date of the Master Policy.

If benefits have been paid under this Policy for an injury incurred while this Policy is in force with respect to the Insured, a re-injury will be considered a new injury if:

- a) The re-injury occurs while this Policy is in force with respect to the Insured; and
- b) The Insured remains treatment free for a period of **180** days between the date of last treatment for the original injury and the date of the re-injury. A re-injury that is incurred within **180** days of the original injury will be considered a continuation of the original injury.

**INSURED** means an eligible student as outlined in this Policy and has paid the required premium. The words he, his, and him refer to the Insured.

**LOSS** means medical expense covered by this Policy as the result of Injury.

**MEDICALLY NECESSARY** means health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, Injury, disease or its symptoms, and that are: (1) In accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, Injury or disease; and (3) not primarily for the convenience of the patient, Physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, Injury or disease. For the purposes of this subsection, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

**OTHER VALID AND COLLECTIBLE HEALTH INSURANCE PLANS** means all other valid and collectible Hospital, medical, dental or surgical coverage providing benefits for covered medical services of the kind described in this Policy. Other Valid and Collectible Group Insurance includes but is not limited to group or blanket insurance policies; Hospital or medical service plan contracts; HMO or other prepayment plans; employee benefit plans; any plan arranged through an employer, labor union, employee benefit association or trustee; any group plan created or administered by the federal or a state or local government or its agencies; or automobile medical payments and no-fault insurance. "Other insurance" shall not include accidental death and dismemberment insurance of any kind.

**OUT-OF-POCKET-LIMIT** means the total maximum dollar amount that a Covered Person must pay as Coinsurance for services and supplies for a covered Injury. All amounts paid as Coinsurance shall count

towards the maximum Out-Of-Pocket-Limit. Once the maximum Out-Of-Pocket-Limit is met all services and supplies shall be covered at 100% of Usual and Customary Charge up to the policy limit with no Coinsurance. Balances over the Usual and Customary Charge and the Deductible do not apply to the Out-Of-Pocket-Limit dollar amount.

**PHYSICIAN** means a duly licensed medical practitioner of the healing arts who: (1) is acting within the scope of the practitioner's license; and (2) is not the Insured or an Immediate Family Member.

**PHYSIOTHERAPY** means any form of physical therapy, whether by machine or hand, by use of exercise, manipulation, massage, adjustment, heat or cold, air, light, water, electricity or sound.

**POLICY** means the contract issued to the Policyholder providing the benefits described.

**POLICYHOLDER** means the legal entity in whose name this Policy is issued, as shown on the Schedule of Benefits. The terms you, your, and yours mean the Policyholder.

**RESIDENCE** means the home and land or property on which the Insured's home is located.

**SCHOOL SPONSORED AND SUPERVISED ACTIVITY [REGULARLY SCHEDULED ACTIVITY]** means all school functions which are organized and scheduled solely by the school on or off school premises. This would include: (1) classes which are under the sole direct supervision of qualified school authorities; and (2) school sponsored and supervised travel to and from such activities, as provided in the insuring clause.

**SURGICAL EXPENSE** means (a) a Surgical Procedure; (b) necessary preoperative treatment in connection with such procedure; and (c) usual postoperative treatment.

**SURGICAL PROCEDURE** means (1) a cutting procedure; (2) suturing of a wound; (3) treatment of a fracture; (4) reduction of a dislocation; (5) electrocauterization; (6) diagnostic and therapeutic endoscopic procedures; and (7) an operation by means of laser beam.

**USUAL AND CUSTOMARY CHARGE** means those charges for necessary treatment and services that are reasonable for the treatment of cases of comparable severity and nature. This will be derived from the mean charge based on the experience in a related area of the service delivered.

## EXCLUSIONS

Benefits are not paid for:

1. Injuries which are not caused by an Accident;
2. Injury sustained as a result of practice or play in senior high interscholastic tackle football, unless the premium for such coverage has been paid;
3. Charges incurred in connection with a re-injury or complications of a condition for which medical advice or treatment was recommended by a Physician or received from a Physician within a 6 month period preceding the effective date of the Insured's coverage[, unless such charges are incurred after the Insured has been insured under this Policy for 6 consecutive months;
4. Treatment performed by an Immediate Family Member or person retained by the School;
5. Injury due to: acts of war; suicide or intentionally self-inflicted Injury, while sane or insane (in Missouri while sane); violating or attempting to violate the law, fighting or brawling except in self defense, or Loss in consequence of being legally intoxicated as defined by the laws of the state in which the Loss occurs; or the voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as now or hereafter amended, unless administered by or on the advice of a Physician;
6. Medical expenses for which the Insured is entitled to benefits under any (1) Worker's Compensation act; or (2) mandatory no-fault automobile insurance contract;

7. Expenses for which there is no obligation to pay;
8. Treatment or Loss resulting from hernia, regardless of cause, Osgood Schlatter's disease, or osteochondritis;
9. Injury sustained as a result of operating, riding in or upon, or alighting from an ATV (all terrain vehicle); or any two, three or four wheeled recreational motor vehicle; or snowmobile; or bobsled;
10. Any expense for which benefits are payable under Catastrophic Accident Insurance Program of the State High School Interscholastic Activities Association;
11. Bacterial infections, sickness or disease of any kind such as strep throat or tonsillitis, heat exhaustion, sunburn, frostbite, fainting, allergic reactions, except those which occur as a result of accidental ingestion or pus forming infections which occur through an accidental cut or wound;
12. Vegetation poisoning such as poison ivy or poison sumac, or ptomaine poisoning;
13. Expense incurred for treatment of temporomandibular joint dysfunction and associated myofacial pain;
14. Private air travel, to include ballooning or ultra-light aircraft; parachuting; or hang-gliding;
15. Experimental procedures;
16. Serving in the armed forces of any country or international authority.
17. Expenses incurred for dental implants.

### **STUDENT ACCIDENT ONLY BENEFITS**

All benefits are subject to any Deductible, Coinsurance and Out-Of-Pocket-Limit amounts shown on the Schedule of Benefits. If the insured is covered under any Other Valid and Collectible Health Insurance Plans and has satisfied all or part of any Deductible amount under that plan, then that satisfied amount will be considered a Disappearing Deductible and the Deductible will be reduced by the amount satisfied under the other plan.

### **MAXIMUM BENEFIT LIMITATIONS**

Maximum Benefit Limitations are stated in the Schedule of Benefits.

### **HOSPITAL AND PROFESSIONAL SERVICES BENEFIT**

Upon receipt of due proof that an Insured incurred Medically Necessary expenses for Hospital and Professional Services, as the result of a covered Injury, we will pay benefits as shown in the Schedule of Benefits. Such Injury must be treated within the number of days stated in the Schedule of Benefits. Services must be given: (1) by a legally qualified Physician; (2) for Medically Necessary medical, dental or Hospital care; and (3) within the time limit stated in the Schedule of Benefits. Benefits, in excess of the Deductible, Coinsurance, and Out-Of-Pocket-Limit amount, are paid to the maximum stated in the Schedule of Benefits for any one Injury.

### **Excess Provision**

We will not pay any Hospital, surgical or medical expenses under any provisions, to the extent that those same expenses are paid or payable under any of the following plans: Individual, Group, Blanket Franchise Plans, or Union Welfare Plans, including Group Blue Cross and Blue Shield. However, if such expenses remain unpaid after such plans have paid their benefits in full, we will pay such remaining expenses, which are covered under this policy. The same terms of the Policy will apply in paying such remaining expenses.

1. The Policyholder shall pay 100% of the premium.

This provision will apply even though the plans named above contain coordination of benefits, non-duplication of benefits or similar provisions.

This provision will only apply when there is no identifiable charge, to the parent or student, for coverage.

### **DENTAL COVERAGE BENEFIT**

Upon receipt of due proof that an Insured incurred Medically Necessary expenses for dental treatment performed as a result of an Injury, covered by this Policy, we will pay the benefit shown in the Schedule of Benefits.

This benefit covers Accidents occurring during covered School Sponsored and Supervised Activities. This includes all athletics and all forms of transportation. Coverage begins on the effective date of the Master Policy and ends on the termination date of the Master Policy.

The Insured must be treated by a legally qualified dentist, who is not an Immediate Family Member. The initial treatment must be rendered within 60 days from the date of Injury. Services must be rendered within the time period shown in the Schedule of Benefits. This benefit covers the treatment of sound and natural teeth as well as capped or crowned teeth. Benefits, in excess of the Deductible, Coinsurance amount, are paid to the maximum stated in the Schedule of Benefits, for any one Injury.

### **Excess Provision**

If there is other valid coverage providing benefits for the same Loss, benefits shall be paid first by the other coverage. The balance of unpaid eligible dental expenses will then be paid under this Policy.

This provision will only apply when there is no identifiable charge, to the parent or student, for coverage.

### **Additional Exclusions**

Benefits will not be paid for:

1. Conditions which are not caused by Injury;
2. Re-injury or complications of a condition which existed prior to the Accident; or
3. Orthodontics and damage to or Loss of dentures or bridges.

All other conditions and provisions remain unchanged.

### **ACCIDENTAL DEATH, DISMEMBERMENT, AND LOSS OF SIGHT BENEFIT**

Upon receipt of due proof that an Insured sustains a Loss, we will pay the benefit shown in the Schedule of Benefits provided:

- (1) such Loss occurs within 100 days after the date of the Accident causing such Loss; and
- (2) such Injury results directly and independently of all other causes; and
- (3) such Injury is sustained while the Insured is covered under this policy.

"Loss" under this benefit shall mean with regard to hands and feet, actual severance above the wrist or ankle joint; with regard to sight, the entire and irrevocable loss thereof.

If the Insured sustains more than one of the losses, shown in the Schedule of Benefits, in one Accident, the total amount payable is the largest specified which applies to the Loss sustained as shown in the Schedule of Benefits.

Any benefit payable under this provision is in addition to any benefit otherwise payable under this Policy. Benefit amounts are stated in the Schedule of Benefits

## **VOLUNTARY PARTICIPATION DENTAL COVERAGE BENEFIT**

Upon receipt of due proof that an Insured incurred expenses for dental treatment performed as a result of Injury, covered by this Policy, we will pay the benefit as shown in the Schedule of Benefits.

This benefit covers Accidents occurring anytime and anywhere. This includes all athletics and all forms of transportation. Coverage begins on October 1 if the Voluntary Participation enrollment envelope is returned to the School in September. Enrollments received after September 30 will become effective on the 1<sup>st</sup> of the month following receipt by the company. Coverage terminates on September 30 of the following year.

The Company will pay for each treatment and service the amount shown in the Schedule of Benefits, when the Insured receives necessary treatment and services commencing within 60 days of the date of Accident, by a legally licensed and practicing dentist. Benefits, in excess of the Deductible amount, are paid to the maximum stated in the Schedule of Benefits, for any one Injury.

### **Additional Exclusions**

Benefits will not be paid for:

- 1) Conditions which are not caused by Injury;
- 2) Expenses resulting from accidental Injury occurring while this Benefit is not in force;
- 3) Injury caused by war or act of war, or while in the armed forces;
- 4) Congenital dental injuries or defects, which are not caused by Injury sustained within this Benefit term.

All other conditions and provisions remain unchanged.

## **STUDENT ACCIDENT ONLY 24-HOUR COVERAGE BENEFIT**

Each person who pays the required 24-Hour Premium is insured on a 24-hour per day basis. Coverage is subject to all Deductibles, Co-Insurance, Exclusions and Limitations shown in this Policy.

## **STUDENT DISABILITY BENEFIT**

The student (or Eligible Person) for whom the school pays the Student Disability premium is covered for Injury as a result of an Eligible Person becoming disabled. For the purposes of this benefit, the following definitions have been added:

**BRAIN DEATH** means irreversible unconsciousness with total loss of brain function and complete absence of electrical activity of the brain even though the heart is still beating.

**COMA** means a profound state of complete and total unconsciousness from which the Insured, through powerful stimulation, is not likely to be aroused. This condition must be diagnosed and regularly treated by a Physician.

**COVERED SCHOOL ACTIVITY** under this benefit means regularly planned school interscholastic athletics functions which are organized and scheduled solely by the school on or off school premises, including games, scrimmages and practice sessions involving: interscholastic athletes, band members, cheerleaders, majorettes, and student managers.



**DISABILITY** under this benefit means Coma, Brain Death or Paralysis of two or more limbs, caused by an Injury while participating in a Covered School Activity. Such disability must continue for 6 months and be diagnosed by a Physician as being permanent.

**ELIGIBLE PERSON** under this benefit means a Student of the policyholder for whom the appropriate disability premium has been paid and who participates in the Covered School Activity.

**INJURY** under this benefit means coma, brain death or paralysis of two or more limbs, caused while participating in a Covered School Activity. Such Injury must continue for 6 months and be diagnosed by a Physician as being permanent.

**PARALYSIS/PARALYZED** means the complete inability to move one or more limbs as a result of neurological damage. This condition must be diagnosed and regularly treated by a Physician.

### **Benefits**

We will pay a benefit as shown in the Schedule of Benefits, if an Eligible Person sustains an Injury that results in a Disability, as defined herein, while participating in a Covered School Activity and while this Policy is in force, subject to the following:

- 1) The Injury results in Coma, Brain Death, or Paralysis of two or more limbs;
- 2) The Disability continues for 6 months; and
- 3) A Physician has diagnosed the Disability as being permanent.

Benefits are paid directly to the Eligible Person, or parent or guardian of the Eligible Person, if a minor.

### **Additional Exclusions**

Benefits will not be paid for:

- 1) Conditions which are not caused by an Injury;
- 2) Expenses resulting from an Injury occurring while this Benefit is not in force;
- 3) Injury not sustained during a Covered School Activity;
- 4) Intentionally self-inflicted Injury, suicide or attempted suicide, while sane or insane;
- 5) Injury caused by war or act of war, or while in the armed forces;

All other conditions and provisions remain unchanged.

## **MANDATED BENEFITS**

### **ACCIDENTAL INGESTION OR CONSUMPTION OF A CONTROLLED DRUG BENEFIT.**

Coverage will be provided for benefits for expenses of emergency medical care arising from accidental ingestion or consumption of a controlled drug, which are at least equal to the following minimum requirements:

**Inpatient Benefit:** at least 30 days in any Calendar Year.

**Outpatient Benefit:** maximum of \$500 during Calendar Year.

Covered expenses means the reasonable charges for treatment deemed Medically Necessary under generally accepted medical standards.

### **AMBULANCE SERVICES BENEFIT**

Coverage will be provided for Medically Necessary ambulance services for persons covered by this Policy.

The hospital policy shall be primary if a person is covered under more than one policy.

This Policy shall cover such services whenever any person covered by the contract is transported when Medically Necessary by ambulance to a Hospital. Such benefits shall be subject to any Policy provision which applies to other services covered by such policies. This Policy will not be required to provide benefits in excess of the maximum allowable rate established by the Department of Public Health.

Payments shall be paid directly to the ambulance provider rendering such service if the provider has complied with the provisions of this subsection and has not received payment from any other source.

Any ambulance provider submitting a bill for direct payment shall stamp the following statement on the face of each bill: "NOTICE: This bill is subject to mandatory assignment pursuant to Connecticut general statutes."

### **HOME HEALTH CARE BENEFIT**

Coverage will be provided for Home Health Care which shall consist of, but shall not be limited to, the following:

- (1) Part-time or intermittent nursing care by a Registered Nurse or by a licensed Practical Nurse under the supervision of a Registered Nurse, if the services of a Registered Nurse are not available;
- (2) part-time or intermittent home health aide services, consisting primarily of patient care of a medical or therapeutic nature by other than a registered or Licensed Practical Nurse;
- (3) physical, occupational or speech therapy;
- (4) medical supplies, drugs and medicines prescribed by a Physician, an advanced practice Registered Nurse or a Physician assistant and laboratory services to the extent such charges would have been covered under this Policy or contract if the Insured had remained or had been confined in the Hospital;
- (5) Medical social services provided to or for the benefit of an Insured diagnosed by a Physician as terminally ill with a prognosis of 6 months or less to live. Medical social services are services rendered, under the direction of a Physician by a qualified social worker holding a master's degree from an accredited school of social work, including but not limited to (A) assessment of the social, psychological and family problems related to or arising out of such Insured 's illness and treatment; (B) appropriate action and utilization of community resources to assist in resolving such problems; (C) participation in the development of the overall plan of treatment for such Insured .

The number of Home Health Care visits for which benefits are payable:

1. will be 80 visits in any Calendar Year or in any continuous period of twelve months for each person covered under a policy;
2. in the case of an Insured diagnosed by a Physician as terminally ill with a prognosis of 6 months or less to live, the yearly benefit for medical social services shall not exceed \$200. Each visit by a

representative of a home health agency shall be considered as 1 home health care visit; 4 hours of home health aide service shall be considered as 1 home health care visit.

The annual Deductible for these benefits is \$50 for each Insured under this Policy and is subject to Coinsurance which provides for coverage of 75% of the reasonable charges for such services. The maximum limitations of this Policy apply to the Home Health Care benefits.

**HOME HEALTH CARE** means the continued care and treatment of an Insured who is under the care of a Physician but only if:

- (1) continued hospitalization would otherwise have been required if home health care was not provided, except in the case of an Insured diagnosed by a Physician as terminally ill with a prognosis of 6 months or less to live, and
- (2) the plan covering the home health care is established and approved in writing by a Physician within 7 days following termination of a Hospital confinement as a resident inpatient for the same or a related condition for which the Insured was hospitalized.

**Exception:** In the case of an Insured diagnosed by a Physician as terminally ill with a prognosis of 6 months or less to live, such plan may be established and approved at any time irrespective of whether such Insured was so confined or, if such Insured was so confined, irrespective of such seven-day period, and (C) such home health care is commenced within 7 days following discharge, except in the case of an Insured diagnosed by a Physician as terminally ill with a prognosis of 6 months or less to live.

- (3) Home health care shall be provided by a home health agency. "Home health agency" means an agency or organization which meets each of the following requirements: (1) It is primarily engaged in and is federally certified as a home health agency and duly licensed, if such licensing is required, (2) its policies are established by a professional group associated with such agency, including at least one Physician and at least one Registered Nurse, to govern the services provided, (3) it provides for full-time supervision of such services by a Physician or by a Registered Nurse, (4) it maintains a complete medical record on each patient, and (5) it has an administrator.

Benefits are not required to be provided beyond the maximum amount limits contained in this Policy.

If a person is eligible for home health care coverage under more than one policy, the home health care benefits shall only be provided by that policy which would have provided the greatest benefits for hospitalization if the person had remained or had been hospitalized.

#### **EFFECTIVE DATE, POLICY TERM AND POLICY TERMINATION**

This Policy takes effect and terminates on the dates stated in the Schedule of Benefits of this Policy. Coverage is afforded for the term or terms designated. All periods of insurance shall begin at 12:00 A.M. Standard Time, at the address of the Policyholder.

#### **EFFECTIVE DATE AND TERMINATION DATE OF INDIVIDUAL VOLUNTARY PARTICIPATION STUDENT ACCIDENT ONLY INSURANCE**

The insurance of each Insured who applies for insurance on or before the effective date hereof shall take effect on the effective date of this Policy. Insurance of any Insured applying for insurance after the effective date hereof shall take effect on the date of application and receipt of premium.

The Insured's coverage will end on the following date:

1. School Time Plan - The termination date shown in the Schedule of Benefits.

2. 24-Hour Plan - The opening day of the next academic year.

## GENERAL PROVISIONS

**ACTS OF THE POLICYHOLDER** In administering this Policy all Insureds must be treated equally. We will rely on your acts.

**CLERICAL ERROR** Clerical errors or delays in keeping records for this Policy will not deny insurance which would otherwise have been granted; nor extend insurance which otherwise would have ceased and call for a fair adjustment of premium and benefits to correct the error.

**CONFORMITY TO LAW** Any provision of this Policy which, is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

**ENTIRE CONTRACT; CHANGES** This Policy, your application, and any endorsements or other attachments is the entire contract between you and us. Any statement you or the Insured makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between you and us. No change in this Policy will be effective until it is approved by one of our executive officers. This approval must be noted on or attached to this Policy. No agent or other person has authority to change this Policy or to waive any of its terms.

**NONPARTICIPATING** This Policy is a nonparticipating Policy; it does not share in our surplus.

**PREMIUM DUE DATE** The premium is due on this Policy's Effective Date. Premiums are payable at the Company's Home Office, Cedar Rapids, Iowa or to an authorized representative.

**RECORDS** Sufficient records must be maintained to show the names of all Insureds; the dates they became insured; and any such other information required to administer this Policy.

**RIGHT TO TERMINATE** You or we may end this Policy at any time by giving written notice to the other party thirty-one (31) days prior to the effective date of termination. You must notify all Insureds of such Policy termination.

## CLAIM PROVISIONS

**BENEFICIARY** The Insured's beneficiary is the person or persons designated by the Insured in writing and entered in the insurance records for this Policy. The Insured may change such designation by written notice to the Policyholder.

A beneficiary change becomes effective only when the new designation is entered in such records. But the change then relates back to take effect as of the date the Insured signed the notice, even though the Insured may not be living when the entry is made. Any payment or other action by the Company before the entry is made will not prejudice the Company.

An Insured does not need the consent of the beneficiary to make a beneficiary change.

**FACILITY OF PAYMENT** If the beneficiary is a minor, or for any other reason is not capable of giving, a valid release for any payment due, we may, at our option, and until claim is made by the duly appointed guardian of the beneficiary, make such payment to:

- (a) any relative of the beneficiary by blood or marriage; or
- (b) any other person or institution which appears to us to have assumed custody and principal support of the beneficiary.

Such payment(s) may not exceed \$100 per month. They must be made for the sole benefit of the beneficiary.

If, with respect to any amount of insurance payable at the Insured's death,

- (1) no beneficiary designation is in effect, or
- (2) no designated beneficiary is then living,

We may pay, at our option, such amount to the Insured's estate or to any one or more of the following who survive the Insured:

- (A) wife or husband;
- (B) children, including adopted or stepchildren;
- (C) mother or father;
- (D) brothers or sisters.

Our liability shall be fully discharged to the extent of payment made under this provision.

**LEGAL ACTIONS** No legal or equitable action can be brought against us:

- (a) before 60 days following the date proof of Loss is sent to us;
- (b) or after 3 years following, the date proof of Loss is due.

**NOTICE AND PROOF OF CLAIM** A claimant must give us written notice of a claim within {20 - 60} 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 claimant's name and policy number. It may be sent to our Home Office or an authorized representative.

When we receive notice of claim, we will send our forms for giving proof of Loss. The forms will be sent within 15 days after our receipt of notice of claim. If the forms are not received, the claimant will have satisfied the proof of Loss requirement if a written notice of the occurrence, character and nature of the Loss is sent to us.

Written proof of Loss must be sent to us within 90 days after the date of Loss. If the claimant is unable to send it within that time, it may be sent as soon as reasonably possible without affecting the claim.

**PAYMENT OF CLAIMS** All benefits of this Policy, except those for Loss of life, are payable to the Insured. In the event the Insured is a minor, we will pay any amount otherwise payable to him as Insured to a relative or beneficiary or other person we deem entitled to the payment. Benefits for Loss of life under Accidental Death and Dismemberment Insurance are payable to the Insured's beneficiary or to one or more other persons under terms of the Facility of Payment provision. Payment so made will satisfy our duty to make payment as to the limited benefit paid. We do not assume any responsibility for the validity of any assignment.

**PHYSICAL EXAMINATION AND AUTOPSY** While a claim is pending, we have the right and opportunity, at our expense:

- (a) to examine the person of the individual for whom claim is made when and so often as it may reasonably require during the pendency of claim under this Policy by a Physician when and as often as we feel necessary; and

- (b) also the right and opportunity to request an autopsy in case of death where it is not prohibited by law.

**RIGHT OF SUBROGATION** We will be fully and completely subrogated, to the extent permitted by law, to the rights of a Covered Person against parties who may be liable to provide indemnity or make a contribution with respect to any matter that is the subject of a claim under the Policy.

The Covered Person further agrees to cooperate fully with us in seeking such indemnity or contribution including, where appropriate, when we are instituting proceedings at its own expense against such parties in the name of the Covered Person. The Covered Person further agrees that the Company will have a lien to the extent of benefits provided. Such lien may be filed with the person whose act caused the Injury, the person's agent or a court having jurisdiction in the matter.

**RIGHT TO RECOVERY** If payments for claims exceed the Maximum amount payable under any benefit provisions or riders of this Policy, we have the right to recover the excess of such payments.

**TIME OF PAYMENT OF CLAIM** Benefits payable under this Policy for any loss will be paid immediately upon receipt of due written proof of such Loss.

**Monumental Life Insurance Company  
Stonebridge Casualty Insurance Company  
Stonebridge Life Insurance Company  
Transamerica Financial Life Insurance Company  
Transamerica Life Insurance Company**

## **NOTICE OF PRIVACY POLICY**

### **Information Only – No Response Necessary**

Protecting your privacy is very important to us. We want you to understand what information we collect and how we use it. We collect and use nonpublic personal information in order to provide our customers with a broad range of financial products and services. We treat your information with the utmost respect and in accordance with our Privacy Policy.

#### **What Information We Collect and From Whom We Collect It**

We may collect nonpublic personal information about you from the following sources:

- Information we receive from you on applications or other forms;
- Information about your transactions with us, our affiliates, or others; and
- Information we receive from non-affiliated third parties, including consumer reporting agencies and insurance support organizations.

Nonpublic personal information is nonpublic information about you that we obtain in connection with providing a financial product or service to you. In some states, personal information may also include your name, address and medical record information but not privileged information. This information may be collected in person, by mail, fax, or by other electronic means as permitted by law or as expressly authorized by you.

#### **What Information We Disclose and To Whom We Disclose It**

Depending upon the product or service offered, we may disclose nonpublic personal information we collect to:

- Persons or companies that perform services on our behalf.
- Other financial institutions with which we have joint marketing agreements as permitted by law. In Vermont this includes only your name, contact information, policy coverage and information about your transactions with us or our affiliates.
- A medical professional for the purpose of disclosing a medical problem of which you may not be aware.
- Other insurance support organizations for use in connection with an insurance transaction or to prevent fraud.
- An insurance regulatory authority.
- A law enforcement or other governmental authority to prevent or prosecute fraud or other unlawful activities.
- Organizations conducting actuarial research studies.
- If applicable, a group policyholder for reporting claims experience or conducting an audit.

We do not disclose any nonpublic personal information about you to either our affiliates or non-affiliates, except as permitted by law. Our affiliates are companies with which we share common ownership. They offer life and health insurance and pension and savings products. Nonpublic personal information about you that we obtain from a report prepared by an insurance support organization may be retained by that organization and disclosed to other persons.

#### **Your Right to Verify Accuracy of Information We Collect**

Keeping your information accurate and up to date is very important to us. In some states, you may have the right to write to us in order to request that you have reasonable access to your nonpublic personal information (this includes a record of any subsequent disclosures of medical record information). You may not access information relating to or in anticipation of a claim or a criminal or civil proceeding. If you believe the information we collected about you is inaccurate, you may request that we amend, correct or delete it. We will notify you of our decision, give you our reasons and the opportunity to file a concise statement of dispute with us if you do not agree. Your statement will be made a part of our file and sent to persons or organizations that received your information in the past and in the future as required by law.

#### **Our Security Procedures**

We restrict access to nonpublic personal information and only allow disclosures to persons and companies as permitted or required by law to assist in providing products or services to you. We maintain physical, electronic, and procedural safeguards to protect your nonpublic personal information. Should your relationship with us end, we will maintain and only disclose your nonpublic personal information in accordance with this Privacy Policy.

**BOLLINGER, INC.**  
**PRIVACY POLICY**  
**(05/10)**

Protecting you and your family from loss is important to Bollinger. Just as important to us is protecting your privacy and the personal information we use to provide you with superior products and service.

The policy of Bollinger and its subsidiaries is to maintain appropriate confidentiality with regard to all personal information obtained in the course of doing business with you. Our pledge to protect your privacy is reflected in this Privacy Policy which outlines our procedures for collecting, using and safeguarding your personal information and information about your relationship with us.

**Personal Information Bollinger Collects**

Bollinger only collects personal information about you when it is necessary to conduct the business of insurance. We limit the collection of personal information to what we reasonably believe is needed to administer your account. As a result, we collect personal information from the following sources:

- Personal information you share with us directly, such as the information on your insurance application, requested policy change information or other forms you may complete;
- Personal information you provide or which is obtained through the process of handling a claim, including medical information, such as from an accident or doctor report;
- Personal information about you from your transactions with us such as the type of coverage you purchase;
- Personal information about you from a consumer reporting agency, such as a Motor Vehicle Report.

If you visit or use any of the Bollinger websites, we may use “cookies” (small text files transferred from our website to your hard drive) to recognize repeat users, track usage and facilitate your access to and use of the site. We do not use “cookies” to gather personal information, and we do not link “cookies” to identifiable information, they are only used to enable you to use our websites more easily.

**Personal Information Bollinger Discloses**

Bollinger is permitted by law to disclose your personal information in the situations described below without your permission.

- To a third party if the disclosure will enable that party to perform a business, professional or insurance function for us. This includes to a consumer reporting agency for the purpose of obtaining a credit report or a Motor Vehicle Report in order to determine eligibility for coverage or to process your requested transaction;
- To an insurance company in order to detect or prevent criminal activity, fraud, or misrepresentation in connection with an insurance transaction;
- To an insurance company for the purpose of performing a function in connection with an insurance transaction involving you;
- To insurance companies for the purpose of seeking multiple quotes for your insurance needs; and
- To an insurance regulatory authority, law enforcement, or other governmental authority as required by law, or in order to protect our interests in preventing or prosecuting fraud, or if we believe that you have conducted illegal activities.

**Protected Health Information Bollinger Discloses**

Bollinger is permitted by law to disclose your Protected Health Information in the situations described below without your permission.

- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected;



- To a medical care institution or medical professional in order to verify coverage, benefits, or treatment in order to process a claim;
- To perform activities or services for your group health plan or the insurance carrier providing the group health plan but only to the extent allowed by law;
- With Bollinger's agents or subcontractors as necessary for Bollinger to perform services on behalf of an insurance company or group health plan but only to the extent allowed by law and pursuant to an agreement by the agent or subcontractor to abide by these privacy rules;
- To an insurance regulatory authority, law enforcement, or other governmental authority as required by law, or in order to protect our interests in preventing or prosecuting fraud, or if we believe that you have conducted illegal activities; and
- Where required by law.

In any situation not specifically addressed in the law, Bollinger must get your written authorization to use or disclose your Protected Health Information. Such authorization may be revoked by you at any time, except if we have already taken action based on your authorization.

### **Your Right to Access and Amend Your Information**

You have the right to request access to your personal information. You may know the source of the information and the identity of the persons to whom we have disclosed such information within the two years prior to your request. You may view the personal information, copy it in person or ask that a copy be sent to you (for which we may charge a reasonable fee to cover our costs). You have the right to request corrections, amendments or deletions to the personal information.

To obtain access to your information: Submit your request in writing to Privacy Officer, Bollinger, Inc., 101 JFK Parkway, Short Hills, NJ, 07078. The request should include your name, address, telephone number and the information to which you would like access. The request should state whether you would like access in person or a copy of the information sent to you. Upon receipt of the request we will contact you within thirty business days to arrange access.

To correct, amend or delete any of the information: Submit a request in writing to Privacy Officer, Bollinger, Inc. 101 JFK Parkway, Short Hills, NJ 07078. The request should include your name, address, telephone number, the specific information in dispute, and the identity of the document or record that contains the disputed information. Upon receipt of your request, we will contact you within thirty business days to notify you that either we have made the correction, amendment or deletion, or we will not do so and our reasons for such refusal, which you will have an opportunity to challenge.

### **Bollinger's Security Practices**

We have a strict Information Security Program in place to safeguard your privacy. We maintain physical, electronic and procedural safeguards that comply with federal and state regulations to protect personal information. Some of these measures involve technology to maintain data security and restrict access to authorized users. Some are more traditional and include training employees about the importance of confidentiality and customer privacy.

### **More Information**

Should you have questions regarding Bollinger, Inc.'s Privacy Policy, you can contact us by writing to Privacy Officer, Bollinger, Inc., 101 JFK Parkway, Short Hills, NJ, 07078; calling directly us at 973-467-0444; or email us at [PrivacyOfficer@BollingerInsurance.com](mailto:PrivacyOfficer@BollingerInsurance.com).