## SECTION I - SCHEDULE

I. **POLICYHOLDER:** Stratford Public Schools
1000 East Broadway
Stratford, CT 06497

II. POLICY NUMBER: MCB 5858877

III. POLICY INCEPTION DATE: August 1, 2015

IV. POLICY PERIOD: August 1, 2015 to August 1, 2016
(All Insurance begins and ends at 12:01 a.m. at the **Policyholder's** address)

V. CONTRACT SITUS: Connecticut

VI. ELIGIBILITY AND CLASSIFICATION OF INSUREDS:

The following individuals are eligible to become **Insureds** upon the submission of completed enrollment material, if required:

Class I: All Enrolled Students of the **Policyholder**.

Class II: All Enrolled Students of the **Policyholder**.

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss**, and he or she is covered under more than one Class, **We** will pay only one benefit, the largest benefit.

VII. **COVERED ACTIVITY(IES):**

Class I: While participating in any of the following **Policyholder** sponsored and supervised activities: interscholastic sports including football; band, cheerleaders & majorettes; intramural sports; student coaches, managers & trainers; nursing program; traveling directly and uninterruptedly to and from such activity with other members as a group. Such travel must be supervised by an authorized representative of the school; 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.

Class II: While participating in any **Policyholder** sponsored and supervised gym classes or Non-sport Extra-Curricular activities; traveling directly and uninterruptedly to and from such activity with other members as a group. Such travel must be supervised by an authorized representative of the school.

VIII. BENEFITS:

| BENEFITS | CLASS COVERED | COVERAGE AMOUNT | FORM NUMBER |
|---|---|---|---|
| Accidental Death Benefit | All | $10,000 | U-BMC-100-A CT (07/10) |
| Accidental Dismemberment Benefit | All | $20,000 | U-BMC-100-A CT (07/10) |
| Exposure and Disappearance Benefit | All | $10,000 | U-BMC-100-A CT (07/10) |
| Catastrophe Cash Benefit | Class I | Initial Lump Sum: $100,000<br>Monthly Amount: $7,500<br>Number of Months: 120 | U-BMC-125-A CW (07/10) |
| Accident Excess Integrated Medical Expense Benefit | All | See Benefit Rider | U-BMC-140-A CT (07/10) |

# Accident Excess Integrated Medical Expense Benefit

ZURICH

**Zurich American Insurance Company**
1400 American Lane
Schaumburg, Illinois 60196

**THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.**

This rider modifies insurance provided under the Blanket Accident Insurance Policy.

**This rider will only be issued if the Policyholder pays 100% of the premium.**

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

| Benefit | Maximum Benefit per **Insured** per **Covered Accident** | Deductible per **Insured** per **Covered Accident** | **Our** share of **Usual and Customary** expenses per **Insured** per **Covered Accident** |
|---|---|---|---|
| Accident Medical | Class I: $5,000,000<br>Class II: $5,000,000 | Class I: $0<br>Class II: $25,000 | Class I: 100%<br>Class II: 100% |

**We** will pay **Our** share of the **Usual and Customary** expenses for **Medically Necessary Covered Medical Service(s)** incurred by the **Insured** resulting from a **Covered Accident** while participating in a **Covered Activity**, up to the Maximum Benefit shown on the Schedule. Coverage is provided in excess of the deductible shown in the above Accident Medical Expense Schedule provided that:

1. the first treatment or service occurs within ninety (90) days of the **Covered Injury**; and
2. the medical expenses are incurred: Class I: within five hundred twenty (520) weeks of the **Covered Injury**.
   Class II: within five hundred twenty (520) weeks of the **Covered Injury**.

For this benefit only, the following definitions apply:

**Covered Medical Service(s)** means any of the following services:

1. **Hospital** room and board expenses: the daily room rate when an **Insured** is **Hospital Confined** and general nursing care is provided and charged for by the **Hospital**. In computing the expenses payable under this benefit, the date of admission will be counted but not the date of discharge.
2. Ancillary **Hospital** expenses: services and supplies including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) when **Hospital Confined**.
3. Medical emergency care (room and supplies) expenses incurred within twenty-four (24) hours of an **Accident** and including the attending **Physician's** charges, X-rays, laboratory procedures, use of the emergency room and supplies.
4. Outpatient surgical room and supply expenses for use of the surgical facility.
5. Outpatient diagnostic X-rays, laboratory procedures and tests.
6. **Physician** non-surgical treatment/examination expenses (excluding medicines) including the **Physician's** initial visit, each necessary follow-up visit and consultation visits when referred by the attending physician.
7. **Physician's** surgical expenses: If a **Covered Injury** requires multiple surgical procedures during the same operative session through the same or different incision, **We** will pay only one benefit, the largest of the procedures performed.
8. Assistant physician expenses when **Medically Necessary**.
9. The services of a registered nurse when **Medically Necessary** (the nurse cannot be a member of the **Insured's** immediate family).

10. Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
11. Outpatient laboratory test expenses.
12. Physiotherapy expenses on an inpatient or outpatient basis limited to one (1) visit per day to a maximum of twelve (12) visits. Expenses include treatment and office visits connected with such treatment when prescribed by a **Physician**, including diathermy, ultrasonic, whirlpool, or heat treatments, adjustments, manipulation, massage or any form of physical therapy.
13. X-ray expenses (including reading charges) but not for dental X-rays unless **Medically Necessary** to evaluate a **Covered Injury**.
14. Radiological procedures.
15. Diagnostic imaging expenses including Magnetic Resonance Imaging (MRI) and Computed Axial Tomography (CAT) Scan.
16. Ambulance expenses for transportation from the emergency site to the **Hospital**.
17. Rehabilitative braces or appliances prescribed by a **Physician**. It must be durable medical equipment that:
    a. is primarily and customarily used to serve a medical purpose;
    b. can withstand repeated use; and
    c. generally is not useful to a person in the absence of Injury.

    No benefits will be paid for rental charges in excess of the purchase price.
18. Prescription drug expenses, for **Covered Injuries**, prescribed by a **Physician** and administered on an outpatient basis.
19. Medical equipment rental expenses for a wheelchair or other medical equipment that has therapeutic value for an **Insured**. **We** will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs, eyeglasses and hearing aids.
20. Expenses for blood and blood transfusions; oxygen and its administration.

**Custodial Services** means non-medical care, including, but not limited to, services:

1. related to watching or protecting the **Insured**;
2. related to performing, or assisting the **Insured** in performing any activities of daily living such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can usually be self-administered; and
3. that are not required to be performed by trained or skilled medical personnel.

**Hospital** means an institution which:

1. operates under the law of the state in which it is situated;
2. is approved by the United States Department of Health and Human Services or its successor;;
3. has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis;
4. has 24-hour nursing service by registered nurses on duty or on call; and
5. is supervised by one of more physicians.

**Hospital** does not include:

1. a nursing, convalescent or geriatric unit of a Hospital when a patient is confined mainly to receive nursing care; or
2. a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged, or any ward, room, wing or other section of a hospital that is used for such purposes.

**Hospital Confined** means admission to a **Hospital** as an inpatient for at least 24consecutive hours by a **Physician**. A **Hospital** stay that does not result in charges to the **Insured** is not a hospital confinement under this rider unless there is no charge because the **Hospital** is a United States government facility.

**In Force Policy** means any multiple group, group-type, family or individual heath care policy covering the **Insured** and in effect at the time of the **Covered Injury**, or subsequently thereafter, other than the **Policy** to which this rider is attached.

**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.

**Pre-existing Condition** means a condition for which an **Insured** received any diagnosis, medical advice or treatment or had taken any prescription medicines during the six (6) months immediately preceding the **Covered Loss**.

**Usual and Customary Expense(s)** means an amount(s) that: (1) does not exceed the usual cost for similar treatment, services or supplies in the locality in which it is incurred; or for a **Hospital** room and board charge other than for stay in an intensive care unit, does not exceed the **Hospital's** most common charge for semi-private room and board or the fee set by the workers' compensation insurance fee schedule, if applicable; and (2) does not include charges that would not have been made if no insurance existed and (3) does not exceed the cost of a generic drug, if available. **We** will only pay up to seventy-five percent (75%) of a non-generic drug if a generic drug is available.

**EXCLUSIONS:**

In addition to the General Exclusions stated in the **Policy**, **We** will not cover expenses under this additional benefit for:

1. Cosmetic, plastic or restorative surgery unless **Medically Necessary** for the treatment of the **Covered Injury**.
2. Any medical expenses related to pregnancy unless **Medically Necessary** for the treatment of the **Covered Injury**.
3. Any expenses for a **Pre-existing Condition**.
4. **Covered Injury** for which the **Insured** is entitled to benefits under Workers Compensation Benefits, Employer Liability Law, or any statutory mandated coverage.
5. Personal comfort or convenience items, such as but not limited to **Hospital** telephone charges, television rental, or guest meals.
6. Treatment by any immediate family member or member of the **Insured's** household.
7. Expenses incurred for dental care, treatment, repair or replacement of sound natural teeth unless **Medically Necessary** for the treatment of the **Covered Injury**.
8. Expenses incurred for eye examinations, eye glasses, contact lenses or hearing aids or the fitting, repair or replacement of these items unless **Medically Necessary** for the treatment of the **Covered Injury**.
9. A hernia.
10. Routine physical examinations and related medical services, or elective treatment or surgery, or experimental or investigative treatments or procedures. However, the exclusion of experimental or investigative treatments or procedures does not apply to those that have successfully completed a phase III clinical trial of the federal Food and Drug Administration.
11. Expenses incurred for psychological or psychiatric counseling of any kind or any expense for treatment of mental or nervous diseases or disorders.
12. Expenses which the **Insured** is not legally obligated to pay.
13. Expenses for **Custodial Services** or services provided by a private duty nurse unless such expenses are incurred as a result of a **Covered Injury**.
14. Expenses related to the repair or replacement of existing artificial limbs, eyes, or other prosthetic appliances, or rental of existing medical equipment unless for the purpose of modifying the item because the **Covered Injury** has caused further impairment of the underlying bodily condition.
15. Treatment involving conditions caused by repetitive motion injuries or cumulative trauma and not a result of a **Covered Injury**.
16. Treatment for osteochondritis due to overuse and occurring during periods of rapid growth, including but not limited to Osgood-Schlatter Disease.
17. 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 prescribed by a **Physician** for the **Insured**. (Accidental ingestion of a poisonous food substance or consumption of a controlled drug is not excluded.)

**EXCESS INTEGRATED**

The benefit amount for this benefit is payable in excess of any **In Force Policy** and its applicable deductible. In the event and only in the event of the reduction or exhaustion of the limit of insurance of the **In Force Policy** solely as the result of actual payment of benefits covered thereunder, this **Policy** shall pay excess of the reduced limit of insurance of the **In Force Policy** and its applicable deductible. This **Policy** shall only pay pursuant to the terms and conditions of this **Policy** and no other policy.

**We** will pay the **Usual and Customary** amount, reduced by the payment by any other insurance plan. This **Policy** will recognize payment by any other insurance plan as reducing or satisfying the deductible amount of this **Policy**. In no event will **We** pay more than the maximum amount stated in this rider.

If no **In Force Policy** exists, this **Policy** will pay benefits on a primary basis.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: August 1, 2015 Attached to and forming a part of **Policy** No. MCB 5858877