Accidental Death & Dismemberment

National Union Fire Insurance Co. of Pittsburgh PA

ARCH INSURANCE COMPANY
(A Missouri Corporation)

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CALIFORNIA BLANKET ACCIDENT POLICY

POLICYHOLDER	**County of San Bernardino**		
POLICY NUMBER	**11BTA0934000**	**POLICY EFFECTIVE DATE**	**July 1, 2019**
POLICYHOLDER ADDRESS	**222 West Hospitality Lane Third Floor San Bernardino, CA 92415**	**POLICY ANNIVERSARY DATE**	**July 1**
POLICY TERM	**July 1, 2019 TO June 30, 2022**		

This Policy takes effect at 12:01 AM on the Policy Effective Date shown above at the address of the Policyholder. The Policy terminates at 11:59 PM on the last day of the Policy Term; unless the Policyholder and the Company agree to continue coverage under this Policy for an additional Policy Term. If coverage is continued for an additional Policy Term and the required premiums are paid on or before the premium date, the Company will issue a Policy to identify the new Policy Term. It continues in effect in accordance with the provisions set forth in this Policy.

The insurance provided by this Policy is limited to the amounts indicated in the Schedule, for the Hazards to be insured against. It is only provided with respect to the Covered Person in the eligible class as shown.

The Company agrees to provide insurance to the Policyholder in exchange for the payment of the required premium. The Policy contains the terms under which the Company agrees to insure Covered Persons and pay benefits.

This Policy is governed by the laws of the state where it was delivered.

IN WITNESS WHEREOF, Arch Insurance Company has caused this policy to be executed and attested.

Patrick K. Nails
Secretary

John Mentz
President

THIS IS A BLANKET ACCIDENT INSURANCE POLICY.
IT PAYS FOR SPECIFIC LOSSES FROM ACCIDENTS ONLY.
THE POLICY DOES NOT PAY BENEFITS FOR LOSSES DUE TO SICKNESS.
PLEASE READ THE POLICY CAREFULLY.

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SECTION I - SCHEDULE OF BENEFITS

POLICYHOLDER	**County of San Bernardino**
POLICY NUMBER	**11BTA0934000**
POLICY EFFECTIVE DATE	**July 1, 2019**
POLICY PERIOD	**July 1, 2019 TO June 30, 2022**
PREMIUM DUE DATE	**Three year annual installments**

CLASSES OF ELIGIBLE PERSONS

A person may be insured only under one Class of Eligible Persons even though he or she may be eligible under more than one class.

Class 1:	All employees and support staff of the sheriff's department and the District Attorney of San Bernardino County who are in Active Service and assigned to the narcotics division, arson/bomb scare squad, Specialized Enforcement Division, scientific investigation bureau including supervising deputy coroner investigators and Investigators of the Consumer and Environmental Protection Unit who regularly work with and are exposed to any hazardous or dangerous substances of the Policyholder.
Class 2:	All Sheriff's Motorcycle Officers.
Class 3:	The Spouse/Domestic Partner and the Dependent Child(ren) of a Class 1 or Class 2 Insured Person

PREMIUMS

$4,088 per year
Payable in 3 annual installments

AGGREGATE LIMIT OF LIABILITY

Benefit Maximum	$4,000,000
Applies During	Per Occurrence
Applies To	Accidental Death & Dismemberment benefits only

HAZARDS

The following are the Hazards for which insurance applies:

Class	Hazard
Class 1	Full Occupational Coverage Business Travel only Exposure and Disappearance Hijacking and Air Piracy Coverage
Class 2	Full Occupational Coverage Business Travel only Exposure and Disappearance Hijacking and Air Piracy Coverage
Class 3	Business Travel only Exposure and Disappearance Hijacking and Air Piracy Coverage

Subject to all the terms and conditions of the Policy, benefits described in the Policy are payable when a Covered Person suffers a Loss or Injury as a result of a Covered Accident during one of the covered Hazards listed above. Benefits are payable only once for any Covered Accident even if it is covered by more than one Hazard. The Benefit amount will be the largest Benefit amount applicable under all such Hazards.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Class 1 and 2 Principal Sum:	$100,000
Class 3 Principal Sum:	$ 1,000
Time Period for Loss:	365 days

ADDITIONAL ACCIDENT BENEFITS
Class 1 and 2

Any benefits payable under these Additional Accident Benefits shown below are paid in addition to any other Accidental Death and Dismemberment benefits payable, unless specifically noted otherwise.

Bereavement and Trauma Counseling Benefit

Benefit Amount	$150 per session
Maximum Number of Sessions	10
Maximum Benefit Per Covered Accident	$1,500

Carjacking Benefit 10% of the Covered Person's Principal Sum up to a Maximum Benefit of $10,000

Child Care Center Benefit

Benefit Amount	$5,000
Maximum Benefit Period	to age 13

Coma Benefit

Class 1 and 2 Maximum Benefit Amount: $100,000

Family Reunion Benefit

Benefit Maximum $5,000

Seatbelt And Airbag Benefit

Seatbelt Benefit	10% of the Covered Person's Principal Sum up to a Maximum Benefit of $10,000
Airbag Benefit	10% of the Covered Person's Principal Sum up to a Maximum Benefit of $10,000

Severe Burn Benefit

Severe Burn of at least:	Benefit (Percentage) of Principal Sum):
75% of body	100%
50% of body	50%
25% of body	25%

Education Benefit	
Surviving Dependent Child Benefit	10% of the Principal Sum subject to a Maximum Benefit of $5,000
Surviving Spouse Benefit	10% of the Principal Sum subject to a Maximum Benefit of $5,000
Home Alteration and Vehicle Modification Benefit	10% of the Covered Person's Principal Sum up to a Maximum Benefit of $10,000
Rehabilitation Benefit	
Benefit per Covered Accident	10% of the Covered Person's Principal Sum up to a Maximum Benefit of $10,000

SECTION II - DESCRIPTION OF HAZARDS

We will only pay benefits if the Insured is engaged in one of the Hazards described below, as listed in the Schedule of Benefits, when the Covered Accident occurs. Unless otherwise specified, We pay benefits only once for any one Covered Accident, even if covered by more than one Hazard. We shall pay the single largest benefit amount applicable under all such Hazards.

Full Occupational Coverage Business Travel (only)

We will pay benefits as shown in the Schedule of Benefits for any Covered Loss resulting directly; and independently of all other causes; from a Covered Accident while the Insured is engaged in this Hazard:

The Covered Accident must take place:

1. on the Policyholder's premises; and
2. in the course of a Covered Person's job or
3. on a business trip authorized by the Policyholder.

This coverage does not include commuting between home and the place of work.

This coverage will start at the actual start of the trip. It does not matter whether the trip starts at the Covered Person's home, place of work, or other place. It will end on the first of the following dates to occur:

1. the date a Covered Person returns to home;
2. the date a Covered Person returns to place of work; or
3. the date the Covered Person makes a Personal Deviation.

"Personal Deviation" means:

1. an activity that is not reasonably related to the Policyholder's business; and
2. not incidental to the purpose of the trip; and
3. such travel or activities must coincide with the Covered Person's Business Travel.

Personal Deviation is limited to any consecutive 14 day period immediately prior to, during or following such Business Travel.

Business Travel (Only)

We will pay benefits as shown in the Schedule of Benefits for any Covered Loss resulting directly; and independently of all other causes; from a Covered Accident while the Insured is engaged in this Hazard; arising from and occurring while the Covered Person is on Business Travel.

Coverage under this Business Travel Hazard begins at the actual start of: Business Travel whether the point of origin is from the Covered Person's residence or regular place of employment, whichever occurs last. Coverage under this Business Travel Hazard ends: immediately upon return to the Covered Person's residence or regular place of employment, whichever occurs first.

"Business Travel" means travel by a Covered Person if:

1) away from such Covered Person's regular place of employment;
2) at the authorization, direction and expense of the Policyholder; and
3) on the business of the Policyholder; and
4) for periods of 365 *days* or less.

Business Travel does not include Commutation. Business Travel includes Personal Deviation.

“Commutation” means travel between a Primary Insured Person's residence and regular place of employment.

"Personal Deviation" means:

1. an activity that is not reasonably related to the Policyholder's business; and
2. not incidental to the purpose of the trip.
3. such travel or activities must coincide with the Covered Person’s Business Travel;
4. Personal Deviation is limited to any consecutive 14 day period immediately prior to, during or following such Business Travel.

Exposure and Disappearance

Coverage under this Hazard includes unavoidable exposure to the elements following a Covered Accident or disappearance of the Covered Person after the forced landing; stranding; sinking; or wrecking of a Conveyance in which the Covered Person was traveling in during the course of a trip which would otherwise be covered under the Policy.

A Covered Person is presumed dead as a result of a Covered Accident if:

1. he or she is in a Conveyance that disappears; sinks; or is stranded or wrecked on a trip covered by this Policy; and
2. the body is not found within one year of the Covered Accident.

Hijacking and Air Piracy Coverage

The Covered Accident must take place during the:

1. hijacking of an Aircraft;
2. air piracy; or
3. unlawful seizure or attempted seizure of an Aircraft.
4. takes place while the Covered Person is in the course of the Policyholder's business.

Coverage begins with the onset of the hijacking or air piracy; and continues while the Covered Person is subject to the control of the person or persons responsible for: the skyjacking or air piracy and during travel directly to his or her home or scheduled destinations. Coverage ends when the Covered Person returns to his or her residence or originally scheduled destination, whichever occurs first.

"Hijacking" or "Air Piracy" means the unlawful seizure or wrongful exercise of control of an aircraft or Conveyance, or the crew thereof, in which the Covered Person is traveling solely as a passenger.

"Conveyance" means any motorized craft, vehicle or mode of transportation licensed or registered by a governmental authority with competent jurisdiction.

Unless otherwise stated in the Schedule of Benefits, We will pay benefits for a Covered Loss, only once, even if coverage was provided under more than one Hazard.

SECTION III - DEFINITIONS

For the purposes of this Policy, certain words with specific meanings are capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found in the Schedule of Benefits or in this Definitions Section.

ACCIDENT means a sudden, unexpected event happening by chance that arises from an external source to the Covered Person and occurs at an identifiable time and place.

ACTIVELY AT WORK means the Covered Person is present at his or her usual place of employment with the Policyholder, or is at another location as assigned or directed by the Policyholder, and is mentally and physically capable of performing the regular duties of the job for which he or she is employed. On any day that is not a Covered Person's regularly scheduled work day (vacation, personal days, and weekends or holidays) the Covered Person will be considered Actively at Work on such day provided he or she is not absent due to any type of leave and was Actively at Work on his or her last regularly scheduled work day. A Covered Person who usually performs the regular duties of his or her job at their home is considered Actively at Work if they meet all the above requirements and could work at the Policyholder's usual place of employment if required to do so.

BENEFIT PERIOD means the period of time, as stated on the Schedule of Benefits, between the date of the Accident causing the Injury for which benefits are payable and the date after which no further benefits will be paid.

BUSINESS TRAVEL means travel by a Covered Person is:

1. away from such Covered Person's regular place of employment;
2. at the authorization, direction and expense of the Policyholder; and
3. on the Policyholder's business; and
4. for periods of 365 days or less.

Business Travel does not include Commutation. Business Travel includes Personal Deviation.

CONVEYANCE means any motorized craft, vehicle or mode of transportation licensed or registered by a governmental authority with competent jurisdiction.

COVERED ACCIDENT means an Accident that occurs while coverage is in force for a Covered Person and results in a Covered Loss or Injury for which benefits are payable.

COVERED DEPENDENT means a Dependent of the Covered Person meeting eligibility under this Policy and for whom the appropriate premium is paid when due.

COVERED EXPENSES means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies covered by this Policy. Coverage under the Policyholder's Policy must remain continuously in force from the date of the Covered Accident until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained.

COVERED LOSS or COVERED LOSSES means an accidental death, dismemberment or other Injury covered under this Policy.

COVERED PERSON means an eligible person who is within the covered class(es) listed in the Policy, and for whom the required premium is paid when due.

DEPENDENT means an Insured's:

1. lawful spouse, if not legally separated or divorced, or Domestic Partner.
2. unmarried children under age 26.
3. unmarried children at least 26 years of age but less than age 30 who are:
   (a) not regularly employed on a full-time basis; and

(b) primarily dependent upon the Insured for support and maintenance; and
(c) enrolled as a full-time student at an accredited college, university or other institution of higher learning or a vocational or licensed technical school.

The age limitations will not apply to a Insured's unmarried child who is incapable of self-support due to a mental disability or physical handicap. Proof of such incapacity must be furnished to the Company immediately upon enrollment or within 31 days of the child reaching the age limitation.
Thereafter proof will be required whenever reasonably necessary, but not more often than once a year after the 2-year period following the age limitation.

The term "child" as used herein means the Insured's natural child, adopted child (or child placed in the Insured's home for purposes of adoption), foster child, stepchild, or other child for whom the Insured has legal guardianship (proof will be required). A child must reside with the Insured in a parent-child relationship and be eligible to be claimed as an exemption on the Insured's federal income tax return. NOTE: In the event the Insured shares physical custody of the child with another parent, the requirement that the child reside with the Insured will be waived.

DOMESTIC PARTNER means a same sex partner or one or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both of the persons are over the age of 62, who have a common residence. Both the Insured and the Domestic Partner must: (1) not be married to someone else or a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity; (2) be at least 18 years of age; (3) not be related by blood in a way that would prevent them from being married to each other in California; and (4) be capable of consenting to the domestic partnership. The Company requires proof of the Domestic Partner relationship in the form of a Declaration of Domestic Partnership filed with the Secretary of State.

HOME COUNTRY means a country from which the Covered Person holds a passport. If the Covered Person holds passports from more than one country, his or her Home Country will be that country which the Covered Person has declared to Us in writing as his or her Home Country.

HOSPITAL means an institution that:
1) operates as a Hospital pursuant to law for the care, treatment and providing in-patient services for sick or injured persons; is a duly licensed institution, operated lawfully in its area;
2) provides 24-hour nursing service by registered nurses on duty or call;
3) has a staff of one or more licensed Physicians available at all times;
4) provides organized facilities for diagnosis, treatment and surgery, either
    a) on its premises; or
    b) in facilities available to it, on a pre-arranged basis;
5) is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and
6) is not a facility for the treatment of drug addiction, alcoholism, treatment of the aged.

We will not deny a claim for services rendered in a hospital having one or more of the following accreditations solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability:
1) the Joint commission of Accreditation of Hospitals; or
2) the American Osteopathic Association; or
3) the Commission on the Accreditation of Rehabilitative Facilities.

IMMEDIATE FAMILY means the Insured's parent, grandparent, spouse, child(ren) (includes legally adopted or step child(ren), brother, sister, step-child(ren), grandchild(ren), or in-laws).

INJURY means bodily injury caused by the direct result of an accident occurring while the Policy is in force as to the person whose injury is the basis of the claim which results directly and independently of all other causes in a Covered Loss.

INSURED means an eligible person who is within the covered class(es) listed in the Policy, and for whom the required premium is paid when due. An Insured is not a Dependent covered under this Policy.

MEDICAL EMERGENCY means a condition caused by an Injury that manifests itself by symptoms of sufficient severity that a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

MEDICALLY NECESSARY means a treatment, service or supply that is:

1) required to treat an Injury;
2) prescribed or ordered by a Physician or furnished by a Hospital;
3) appropriate and consistent with the patient's diagnosis;
4) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

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

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

OCCURRENCE means all losses or damages that are attributable directly or indirectly to one cause or one series of similar causes. All such losses will be added together and the total amount of such losses will be treated as one occurrence without regard to the period of time or the area over which such losses occur.

PHYSICIAN means a person who is a qualified doctor of medicine or dental practitioner As such, he or she must be acting within the scope of his or her license under the laws in the state in which he or she practices and providing only those medical services which are within the scope of his or her license or certificate. It does not include a Covered Person, an Insured's spouse, son, daughter, father, mother, brother or sister or other relative.

TRIP means travel by air, land, or sea from the Covered Person's Home Country.

USUAL AND CUSTOMARY CHARGES means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

WE, OUR, US means the Insurance Company underwriting this insurance or its authorized agent.

YOU, YOUR, YOURS means the Covered Person who meets the eligibility requirements of the Policy and whose insurance under the Policy is in force.

SECTION IV - ELIGIBILITY FOR INSURANCE

If the Covered Person is in one of the classes of Eligible Persons shown on the Policy Schedule of Benefits, he or she is eligible to be covered on the Policy Effective Date. The Company retains the right to: investigate eligibility status; and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

A Covered Person's Dependent(s), as applicable, is eligible on the latest of the date:

1) the Covered Person is eligible, if the Covered Person has Dependents on that date; or
2) the date the person becomes a Dependent; or
3) the next annual enrollment (if applicable) following the date the person becomes a Dependent.

If the Covered Person is in a Class of Eligible Persons and is also eligible as a Dependent, he or she may be

Covered only once under this Policy. In no event will a Dependent be eligible if the Covered Person is not eligible.

SECTION V - EFFECTIVE DATE OF INSURANCE

Policy Effective Date. This Policy begins on the Policy Effective Date shown in the Schedule of Benefits at 12:01 A.M. at the address of the Policyholder.

Covered Person's Effective Date

A Covered Person's coverage under this Policy begins on the later of:

1) the Policy Effective Date; or
2) the date such person becomes eligible, subject to any required waiting period; as described in the Schedule of Benefits.

SECTION VI - TERMINATION DATE OF INSURANCE

Policy Termination Date

Termination takes effect at 11:59 P.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination.

If this Policy terminates due to non-payment of premium, it may be reinstated if mutually agreed upon, in writing, by the Policyholder and the Company. Written request for reinstatement must be made to the Company within 60 days of the termination date. All required premiums must be paid prior to reinstatement.

This Policy terminates automatically on the earlier of:

1) The Policy Termination Date shown in this Policy; or
2) The premium due date if premiums are not paid when due; subject to the grace period provided in the section of this Policy entitled Premium.

Failure by the Policyholder to pay all required premiums due by the last day of the grace period shall be deemed notice by the Policyholder to the Company to terminate this Policy on the last day of the period for which premiums have been paid.

This Policy may be terminated by the Policyholder or the Company as of any premium due date or Policy Anniversary Date by giving written notice to the other at least 31 days prior to such date; unless such longer notice period is required pursuant to applicable insurance regulations.

The Policyholder and the Company may terminate this Policy at any time by written mutual consent.

If premiums have been paid beyond the termination date, the Company will refund the excess; or if premiums have been paid short of the termination date, the Policyholder will owe the Company the difference.

Covered Person's Termination Date

A Covered Person's coverage under this Policy ends on the earliest of:

1) The date this Policy terminates;
2) The date the Covered Person requests, in writing, that his or her coverage be terminated;
3) The date the Covered Person enters full-time active duty in the armed forces of any country or international authority;
4) The date the Covered Person ceases to be eligible as described in this Policy provided all required premiums are paid; or
5) The last day of the period for which premiums have been paid; or
6) The date the Covered Person is no longer Actively at Work, provided all required premiums are paid, unless otherwise provided below.

Any continuation of coverage must be based on rules that preclude individual selection and is subject to this Policy remaining in force.

Covered Dependent's Termination Date

A Covered Dependent's coverage under this Policy ends on the earliest of:

1) The date this Policy terminates; or
2) The date the Covered Person's coverage ends; or
3) The date the Covered Dependent is no longer a Dependent; or
4) The last day of the period for which premiums have been paid.

SECTION VII - DESCRIPTION OF BENEFITS

The following provisions explain the benefits available under the Policy. All benefits payable are shown in the Schedule of Benefits.

AGGREGATE LIMIT OF LIABILITY

The maximum amount the Company will pay for all Covered Losses resulting from the same Covered Accident will not exceed the Aggregate Limit of Liability as described in the Schedule of Benefits.

If the total amount payable for all Covered Losses in any one Accident exceeds the Aggregate Limit of Liability, each Covered Person's Covered Loss will be paid at the same ratio that the Aggregate Limit of Liability has to the total amount of all Covered Losses. The Company shall not be liable for amounts in excess of the Aggregate Limit of Liability.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If Injury to the Covered Person results in any of the Covered Losses shown below, within the Time Period for Loss as shown in Schedule of Benefits, 365 days from the date of the Covered Accident that caused the Injury, the Company will pay the percentage of the Principal Sum shown below for that loss. The Principal Sum is shown in the Schedule of Benefits. If multiple losses occur, only one benefit, the largest, will be paid for all losses due to the same Covered Accident.

Loss of:	**Benefit:**
	Percentage of Principal Sum
Life	100%
Two or More Members	100%
Quadriplegia	100%
Hemiplegia	75%
Paraplegia	75%
One Member	50%
Uniplegia	25%
Thumb and Index Finger of the Same Hand	25%

"Member" means Loss of Hand or Foot, Loss of Sight, Loss of Speech and Loss of Hearing. "Loss of a hand or foot" means complete severance through or above the wrist or ankle joint. "Loss of sight" means total and permanent loss of sight of one or both eyes that is irrecoverable, including by surgical and artificial means. "Loss of speech" means total and permanent loss of audible communication that is irrecoverable by natural, surgical or artificial means. "Loss of hearing" means permanent total deafness in both ears such that it cannot be corrected by any aid or device. "Loss of thumb and index finger of the same hand" means complete severance of each through or above the metacarpophalangeal joint of both digits of the same hand. Severance means the complete separation and dismemberment of the part from the body.

"Paralysis" means total loss of use.

"Hemiplegia" means total Paralysis of the upper and lower limbs on one side of the body.

"Paraplegia" means total Paralysis of both lower limbs.

"Quadriplegia" means total Paralysis of both upper and lower limbs.

"Uniplegia" means total Paralysis of one lower limb or one upper limb.

ADDITIONAL ACCIDENT BENEFITS

Bereavement & **Trauma Counseling Benefit**

If a Covered Person suffers a loss for which Accidental Death and Dismemberment; Coma; Loss of Use or Paralysis; Permanent and Total Disability; or Severe Burn (if shown as a covered benefit under this Policy) Benefits are payable as shown in the Schedule of Benefits under this Policy, the Company will reimburse the Covered Person or the Covered Person's: father; mother; spouse; sons; daughters; brothers or sisters for expenses incurred within one year after the date of the Covered Accident causing such loss for any individual or family counseling sessions up to a maximum shown in the Schedule of Benefits.

The counseling sessions must:

1) be required to assist the Covered Person and/or the Covered Person's father; mother; spouse; sons; daughters; brothers; or sisters in coping with such loss;
2) be ordered and performed by a Physician; and
3) meet generally accepted standards of medical practice.

Only one Bereavement and Trauma Counseling Expense Benefit will be paid regardless of the number of Covered Losses incurred as the result of the same Covered Accident.

The Company will not reimburse expenses:

1) for which no charge would have been made if no insurance existed;
2) in excess of the usual; reasonable; and customary charges for similar counseling sessions in the locality where the sessions are received; or
3) incurred as the result of an Injury caused by an Accident for which the Covered Person is entitled to benefits paid or payable by Workers' Compensation or other similar law.

Carjacking Benefit

We will pay this benefit shown in the Schedule of Benefits if the Covered Person suffers a Covered Loss resulting directly; and independently of all other causes; from a Covered Accident that occurs during a Carjacking of an Automobile that the Covered Person was: operating, getting into to or out of, or riding as a passenger. Verification of the Carjacking must be made part of an official police report with 24 to 48 hours of the Carjacking, or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within 24 to 48 hours of the Carjacking, or as soon as reasonably possible.

Carjacking means a person other than the Covered Person taking unlawful possession of an Automobile by means of force or threats against the person(s) then rightfully occupying the Automobile.

Automobile means a self-propelled private passenger motor vehicle with four or more wheels, that is of a type both designed and required to be licensed for use on the highways of any state or country. Automobile includes, but is not limited to, a sedan; station wagon; sport utility vehicle; pick-up; panel; van; camper or motor home. Automobile does not include a mobile home or any motor vehicle that is used in mass or public transit.

Child Care Center Benefit

If a Covered Person suffers loss of life for which Accidental Death Benefits are payable under this Policy and such Covered Person had the Family Plan in force, the Company will pay an additional benefit shown in the Schedule of Benefits on behalf of a Covered Person's Covered dependent child who, on the date of the Covered Accident:

1. was under age 13 and Covered Person under this Policy; and
2. was enrolled in a Day Care Center on the date of the Covered Person's loss of life; or
3. subsequently enrolls within 90 days of the date of the Covered Person's loss of life in a licensed day care center.

The amount shall be payable per year equal to the lesser of the actual cost charged by a licensed day care center per year or the amount shown in the Schedule of Benefits.

Child Care benefits are payable once a year for not more than four consecutive years, but only if such Covered Dependent child remains under 13 years of age and continues enrollment in a Child Day Care Center (proof of enrollment will be required).

Child means a Covered Person's child under age 13 who is a natural child; adopted child (or child placed in the Covered Person's home for purposes of adoption); foster child; stepchild; or other child for whom the Covered Person has legal guardianship (proof will be required). A child must reside with the Covered Person in a parent-child relationship and be eligible to be claimed as an exemption on the Covered Person's federal income tax return.
NOTE: In the event the Covered Person shares physical custody of the child with another parent, the requirement that the child reside with the Covered Person will be waived.

"**Child Care Center**" means a facility that is duly licensed, certified or accredited by the jurisdiction in which it is located to provide child care and is operating in compliance with applicable laws and regulations of the jurisdiction. A Child Care Center does not include any of the following: 1) a hospital; 2) the child's home; 3) care provided during normal school hours while a child is attending grades one through twelve.

Coma Benefit

If a Covered Person suffers an Injury caused by a Covered Accident which results in such person being in a Coma within 30 days of the Accident and if the Coma continues for at least 30 consecutive days, the Company will pay a monthly benefit equal to 1% of the Covered Person's Principal Sum as shown in the Schedule of Benefits.

No benefit is provided for the first 30 days of Coma. The benefit is paid monthly, beginning on the 31st day of the Coma and ends on the earliest of:

1) the date the Coma ends, whether by death, recovery, or any other change of condition; or
2) after 11 continuous months of benefit payments by the Company, the date the total amount of monthly Coma benefits paid for all Injuries caused by the same accident equals 100% of the Covered Person's Principal Sum.

If the Covered Person suffers loss of life for which benefits are payable under this Policy as a result of the same Covered Accident which caused the Coma, or if he or she remains in a Coma at the end of 11 continuous months, an additional benefit will be paid equal to the Covered Person's Principal Sum as shown on the Schedule of Benefits; less any Coma Benefits paid or other benefits payable under this Policy for any other losses incurred as a result of the same Covered Accident.

Under no circumstances will the Company pay more than the Covered Person's Principal Sum as shown on the Schedule of Benefits for all Covered Losses combined, including this Coma Benefit, which are incurred as the result of the same Covered Accident.

The Covered Person's designated beneficiary is responsible for providing the Company proof of continuing Coma. The Company reserves the right, at the end of the first 30 consecutive days of Coma and as often as it may reasonably require thereafter, to determine, on the basis of all the facts and circumstances, that the Covered Person is in a Coma, including, but not limited to, requiring an independent medical examination provided at the expense of the Company.

"Coma" means being in a state of profound unconsciousness which resulted directly, and independently from all other causes, from a Covered Accident, and from which the Covered Person is not likely to be aroused through powerful stimulation. This condition must be diagnosed and treated regularly by a Physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of an Injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of that Covered Accident.

Family Reunion Benefit

If, while the Covered Person is traveling, he or she suffers an Injury and must be confined in a Hospital for at least 3 consecutive days, We will reimburse the expenses incurred for transportation and lodging for a Family Member to join the Covered Person during his or her stay in the Hospital. All transportation and lodging arrangements must be made by the most direct and economical route and Conveyance possible and may not exceed the usual level of charges for similar transportation or lodging in the locality where the expense is incurred.

Benefits will not be paid unless all expenses are approved in advance by Us, and services are rendered by the Company's assistance provider.

"Family Member" means a parent; sister; brother; husband; wife; or children.

Seatbelt and Airbag Benefit

We will pay this benefit as shown in the Schedule of Benefits subject to the conditions described below, when the Covered Person dies directly; and independently of all other causes; from a Covered Accident while wearing a Seatbelt and operating or riding as a passenger in an Automobile.

An additional benefit is provided if the Covered Person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).

Verification of proper use of the seatbelt at the time of the Covered Accident and/or Airbag inflated upon impact, must be a part of an office policy report of the Covered Accident or be certified in writing, by the investigating officers and submitted with the Covered Person's claim to Us.

If such certification or police report is not available or it is unclear whether the Covered Person was wearing a Seatbelt or had deployed Airbags. We will pay a default benefit of $1,000 to the Covered Person's beneficiary.

"Supplemental Restraint System" means an airbag that inflates upon impact for added protection to the head and chest areas.

"Automobile" means a self-propelled private passenger motor vehicle with four or more wheels, that is of a type both designed and required to be licensed for use on the highways of any state or country. Automobile includes, but is not limited to, a sedan; station wagon; sport utility vehicle; pick-up; panel; van; camper; or motor home. Automobile does not include a mobile home or any motor vehicle that is used in mass or public transit. "Seat Belt" means those belts that form an occupant restraint system and includes infant and child passenger restraint systems when properly used with a seat belt.
"Air Bag" means a Supplemental Restraint System or safety device designed to inflate upon collision.

Severe Burn Benefit

If a Covered Person suffers a Severe Burn as the result of a Covered Accident, the Company will pay a benefit as shown in the Schedule of Benefits.

The determination of whether or not an area of the body is Severely Burned, and what proportion of its surface is Severely Burned, must be made by a Physician. The Company has a right, at its own expense, to have the determination verified by a Physician of the Company's choice.

"Severe Burn or Severely Burned" means cosmetic disfigurement of the surface of a body area due to an Injury caused by an Accident that is a full-thickness or third-degree burn, as determined by a Physician. (A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation).

Under no circumstances will the Company pay more than the Covered Person's Principal Sum for all Covered Losses combined, including this Severe Burn Benefit, which are incurred as the result of the same Accident.

Education Benefit

If a Covered Person suffers loss of life for which Accidental Death Benefits are payable under this Policy and such Covered Person had the Family Plan in force, the Company will pay an additional benefit as shown in the Schedule of Benefits to or on behalf of his or her Covered Dependent child who, on the date of the Covered Accident, was:

1) under age 23 and Covered Person under this Policy; and
2) enrolled as a full-time student in any accredited college; university; or other institution of higher learning; or a vocational or licensed technical school beyond the 12th grade level on the date of the Covered Person's loss of life; or
3) at the 12th grade level and subsequently enrolls as a full-time student at an accredited college; university; or other institution of higher learning; or a vocational or licensed technical school within 365 days after the date of the Covered Person's loss of life.

Education Benefits are payable once a year for not more than four consecutive years, but only while the Covered Person's Covered Dependent Child continues as a full-time student (proof of enrollment for each year will be required).

If, on the date of the Covered Person's loss of life, the Covered Person had no Covered Dependent Child that qualified, a lump sum benefit as shown in the Schedule of Benefits will be paid to the Covered Person's designated beneficiary.

"Child" means a Covered Person's unmarried child under age 23 who is: (a) not regularly employed on a full-time basis; and (b) primarily dependent upon the Covered Person for support and maintenance. The term "child" as used herein means a Covered Person's natural child; adopted child (or child placed in the Covered Person's home for purposes of adoption); foster child; stepchild; or other child for whom the Covered Person has legal guardianship (proof will be required). A child must reside with the Covered Person in a parent-child relationship and be eligible to be claimed as an exemption on the Covered Person's federal income tax return. In the event the Covered Person shares physical custody of the child with another parent, the requirement that the child reside with the Covered Person will be waived.

Home Alteration and Vehicle Modification Benefit

We will pay this benefit as shown in the Schedule of Benefits, subject to the following conditions when the Covered Person suffers a Covered Loss, other than loss of life, resulting directly; and independently of all other causes; from a Covered Accident.

This benefit will be payable if all of the following conditions are met:

1. Prior to the date of the Covered Accident causing such a Covered Loss, the Covered Person did not require the use of any adaptive devices or adaptation of residence and/or vehicle; and
2. As a direct result of such Covered Loss the Covered Person now requires such adaptive devices or adaptation of residence and/or vehicle to maintain an independent lifestyle; and
3. The Covered Person requires home alteration or vehicle modification within one year of the date of the Covered Accident.

Rehabilitation Expense Benefit

If a Covered Person suffers a loss for which Accidental Dismemberment, Coma Benefits are payable, as shown in the Schedule of Benefits, under this Policy, the Company will reimburse the Covered Person for expenses incurred within one year after the date of the Accident causing such loss, as stated herein, per Covered Accident which are charged for:

1. physical; occupational; speech or hearing therapy; or other rehabilitation training for which measurable improvement is expected within a reasonable time; and
2. medically necessary services or supplies related to rehabilitation therapy.

The therapy, training, services or supplies must:

1. meet generally accepted standards of medical practice; and
2. be provided by or under the supervision of a Physician.

Only one Rehabilitation Expense Benefit will be paid regardless of the number of Covered Losses incurred as the result of the same Covered Accident.

The Company will not reimburse expenses:

1. for which no charge would have been made if no insurance existed;
2. in excess of the usual, reasonable and customary charges for similar services in the locality where the services are received for hospital room and board charges, does not exceed the most common charge for semi-private room and board in the hospital where the expense is incurred; or
3. as the result of an Injury caused by an Accident for which the Covered Person is entitled to benefits paid or payable by Workers' Compensation or other similar law.

SECTION VIII - PREMIUM

The Company provides insurance in return for premium payments. The premium showed in the Schedule of Benefits is payable to the Company in the manner described in the schedule; and is based on: rates currently in force; the plan; and the amount of insurance in force. Premium is due on the Policy Effective Date. After that premium will be due monthly unless otherwise stated in the Policy.

The Company has the right to rely upon the accuracy of the Policyholder's calculations; and require the Policyholder to furnish a census from time to time but not more than twice in a 12-month period. If, at any time, it is determined that additional premium or a premium credit is due, the Policyholder will pay the additional premium or apply the premium credit at the next premium due date.

If any premium payment is not paid when due, the Policy will be cancelled as of the premium due date; except as provided under the Grace Period section.

Changes in Premium Rate

The Company may change the premium rates from time to time with at least 31 days advanced written or authorized electronic notice. No change in rates will be made until 12 months after the Policy Effective Date. However, the Company reserves the right to change rates at any time if any of the following events occur:

1) A change in the terms of the Policy.
2) A subsidiary; division; affiliated organization; or eligible class is added or deleted to the Policy.
3) A change in any federal; or state law; or regulation affecting this Policy and our benefit obligation.
4) A change in the factors bearing on the risk assumed.
5) A misrepresentation in the information relied on in establishing the rate for this Policy.
6) The number of Covered Persons or persons eligible for coverage or Estimated Volume of Insurance increases or decreases by more than 10% since the later of the Policy Effective Date or the date of the last renewal of this Policy.
7) The Policyholder fails to provide sufficient information, as required by Us, to confirm adequacy and accuracy of premiums and rates being paid.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date.

Grace Period
A grace period of 31 days will be granted for the payment of premiums accruing after the first premium, during which grace period the policy shall continue in force, but the employer shall be liable to the insurer for the payment of the premium accruing for the period the policy continues in force.

Premium Audit
We will have the right to audit books and records of the Policyholder at its place of business and during its regularly scheduled business hours, in order to determine the accuracy of premiums paid.

New Subsidiary or affiliate company
The premium for this Policy applies only to the Policyholder's organization as composed on the Policy Effective Date as described in the Policy; or as thereafter amended.

The eligible persons of any corporation; partnership; or sole proprietorship acquired by the Policyholder after the Policy Effective Date through merger; stock purchase; exchange of stock; or otherwise may be covered under this Policy subject to the following conditions:

1) the Policyholder must report, in writing, the name of the newly acquired entity and all underwriting information necessary to determine any additional premium required; and
2) Underwriting and acceptance of the new entity by the Company; and
3) the Policyholder must agree to, and must pay, any required additional premium.

SECTION IX - CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the insurer at Arch Insurance Solutions Inc., Executive Plaza IV, 11350 McCormick Road, Suite 102 Hunt Valley, MD 21031 or to any authorized agent of the insurer, with information sufficient to identify the insured employee, shall be deemed notice to the insurer.

CLAIM FORMS: The insurer, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

PROOF OF Loss: Written proof of loss must be furnished to the insurer, in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which the insurer is liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the employee, later than one year from the time proof is otherwise required.

BENEFICIARY: The Covered Person may designate a beneficiary. The right to change of beneficiary is reserved to the Insured, and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary.

The Insured is the beneficiary for any Covered Dependent.

EXPOSURE AND DISAPPEARANCE: If, by reason of a covered accident, a Covered Person is unavoidably exposed to the elements and as the result of such exposure suffers a loss for which indemnity is otherwise payable, such loss will be covered under the terms of the Policy.

If the body of a Covered Person has not been found within 1 year after the date of disappearance as the result of the sinking or wrecking of the aircraft or watercraft in which the Covered Person was riding at the time of the accident and under such circumstances as would otherwise be covered, it will be presumed that the Covered Person suffered loss of life resulting from Injury caused solely by a Covered Accident.

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured employee. Any other accrued indemnities unpaid at the insured employee's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Insured.

RECOVERY OF OVERPAYMENT: If benefits are overpaid; or paid in error We have the right to recover the amount overpaid; or paid in error by any of the following methods.

1) A request for lump sum payment of the amount overpaid; or paid in error; or
2) Offset or reduction of any proceeds payable under this Policy by the amount overpaid; or paid in error.

RIGHT OF RECOVERY: A Covered Person may incur charges due to an Injury for which benefits are paid by this Policy. The injury may be caused by the act or omission of another person. If so, the Covered Person may have a claim against that other person for payment of expense-incurred charges. If Recovery under the claim is made, the Covered Person must repay Us the Recovery made from: 1) another person; 2) insurance companies; or 3) other organizations.

Recovery means monies paid to the Covered Person through judgment, settlement or otherwise to compensate for all losses caused by the Injury.

Net Recovery means the Covered Person's Recovery less attorney's fees and court costs incurred in making the Recovery. Refund means repayment to Us for benefits paid.

TIME OF PAYMENT OF CLAIMS: Subject to due written proof of loss, all indemnities for loss for which this policy provides payment will be paid as they accrue and any balance remaining unpaid at termination of the period of liability will be paid immediately upon receipt of due written proof.

PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as it may reasonably require during the Pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

SECTION X -GENERAL POLICY PROVISIONS

ASSIGNMENT: This Policy is not assignable, whether by operation of law or otherwise. Benefits may be assigned. No assignment of interest in loss of life benefits shall be binding on the Company until the original or duplicate thereof is received by the Company. The Company assumes no responsibility for the validity of such assignment.

CERTIFICATES OF INSURANCE: Where it is required by law, or upon request of the Policyholder, the Company will make available to all Covered Persons certificates outlining the benefits; conditions; exclusions; and limitations of this Policy.

CLERICAL ERROR: Clerical error in keeping any records pertaining to the coverage, whether by the Policyholder or by the Company, will not invalidate coverage otherwise validly in force; nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to the Company and is rectified promptly upon discovery. No error will continue the insurance of a Covered Person beyond the date it should end under the Policy terms. After an error is found, the Company will take appropriate action, which may include adjusting, collecting or refunding premium.

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which this policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statute.

ENTIRE CONTRACT/CHANGES: This policy and the application of the employer constitute the entire contract between the parties, and any statement made by the employer shall, in the absence of fraud, be deemed a representation and not a warranty. No statement made by any employee whose eligibility has been accepted by the insurer shall (void the insurance or reduce the benefits under this policy or) be used in defense to a claim hereunder.

After two years from the date of issue of this policy, no misstatement of the employer, except a fraudulent misstatement, made in his application shall be used to void the policy; and after three years from the effective date of the coverage with respect to which any claim is made no misstatement of any employee eligible for coverage under the policy, except a fraudulent misstatement, made in an application under the policy shall be used to deny a claim for loss incurred or disability (as defined in the policy) commencing after expiration of such three years.

INSOLVENCY: The insolvency; bankruptcy; financial impairment; receivership; voluntary plan of arrangement with creditors; or dissolution of the Policyholder will not impose upon the Company any liability other than the liability defined in this Policy. The insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including Covered Persons under the Plan.

INCONTESTABILITY: After two (2) years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for the policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of the two (2) year period.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

MISREPRESENTATION AND FRAUD: This entire Policy will be void, whether before or after a loss, if the Company determines that the Policyholder; Covered Person; or its agent has concealed or misrepresented any material fact or circumstance concerning this Policy, including any claim or any case of fraud by the Policyholder; Covered Person; Third Party Administrator; or other agent relating to this Policy.

MISSTATED DATA: The Company has relied upon the underwriting information provided by the Policyholder; its Third Party Administrator; or other Agent in the issuance of this Policy. Should subsequent information become known which, if known prior to issuance of this Policy, would have affected the rates; terms; or conditions for coverage, the Company will have the right to revise the rates; terms; or conditions as of the Effective Date of issuance, by providing written notice to the Policyholder.

PAYMENT OF PREMIUM: The Company provides insurance in return for the payment of premiums. The Premiums are to be paid to the Company by the Policyholder. The first Premium is due on the Policy Effective Date. After that premiums will be due monthly unless shown otherwise in the Schedule of Benefits. If any premium is not paid when due, the Policy will be cancelled as of the Premium Due Date; except as provided in the Policy Grace Period provision.

TRADE OR ECONOMIC SANCTIONS LIMITATIONS: This Policy does not apply to the extent that trade or economic sanctions or regulations prohibit Us from providing insurance, including, but not limited to, the payment of claims.

WAIVER: Failure of the Company to strictly enforce its rights under this Policy at any time or under any circumstance shall not constitute a waiver of such rights by the Company at any time under the same or different circumstances.

WORKERS' COMPENSATION: This Policy is not a Workers' Compensation policy. It does not provide Workers' Compensation benefits; and does not satisfy any requirements for coverage by any Workers' Compensation Act or similar law.

SECTION XI - EXCLUSIONS

This Policy does not cover any loss or Injury resulting or caused, in whole or part, from:

1. Suicide or attempted suicide; self-destruction or attempted self-destruction; while sane or insane.
2. Intentionally self-inflicted injury.
3. War or any act of war or invasion; declared or undeclared.
4. Service, training, or active duty in the armed forces; National Guard; military; naval; or air service; or organized reserve corps of any country or international organization.
5. Piloting or serving as a crewmember or riding in any aircraft except as a fare-paying passenger on a regularly scheduled or charter airline.
6. Intoxication or being under the influence of any controlled substance unless administered on the advice of physician. Intoxication is defined by the laws of the jurisdiction where such Accident occurs.
7. The commission of or attempt to commit a felony by the person whose injury or sickness is the basis of claim, or to which a contributing cause was such person's being engaged in an illegal occupation.
8. To the extent We are prohibited from providing coverage or making payment by any type of travel restriction; trade restriction; economic sanction; or embargo imposed by the U.S. government.
9. Travel in, boarding or alighting from any aircraft Owned; Leased; Controlled; or Chartered by the Policyholder, or any of its subsidiaries or affiliates.
10. Actively participating in acts of terrorism, civil commotion or riots of any kind.
11. Travel or flight in or on any aircraft, including boarding or alighting from:
    a. while riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
    b. while being used for any test or experimental purpose; or
    c. while piloting; operating; learning to operate; or serving as a member of the crew thereof; or
    d. while traveling in any such aircraft or device which is owned; chartered; controlled; or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Covered Person or any member of his household; or
    e. being flown by the Covered Person or which the Covered Person is a member of the crew; or
    f. being used for: i) crop dusting; spraying or seeding; giving and receiving flying instructions; fire fighting; sky writing; sky diving or hang gliding; pipeline or power line inspection; bungee-cord jumping; parasailing; aerial photography or exploration; racing; endurance tests; stunts or acrobatic flying; or ii) any operation that requires a special permit from the FAA, even if it is granted. (This does not apply if the permit is required solely because of the territory flown over or landed on.);
    g. designed for flight above or beyond the earth’s atmosphere;
    h. which is an ultra light; or glider;
    i. being used for the purpose of skydiving; or parachuting;
    j. being used by any military authority; except an aircraft used by the Air Mobility Command or its foreign equivalent.

ARCH INSURANCE COMPANY
(A Missouri Corporation)

CALIFORNIA AMENDATORY RIDER

This Rider is attached to and made part of the Policy and any Certificate issued therewith. It is subject to all of the Policy provisions that do not conflict with its provisions.

1. Under Section X – **CLAIMS PROVISIONS**

The following mandatory provision has been added to the policy and certificate

MEDICAL REVIEW REQUIREMENTS
A Covered Person may request an independent medical review ("IMR") of disputed health care services from the California Department of Insurance if he or she believes that we have improperly denied, modified, or delayed health care services. A disputed health care service is any health care service eligible for coverage and payment under the Covered Person's coverage that has been denied, modified, or delayed by us, in whole or in part because the service is not Medically Necessary.
The IMR process is in addition to any other procedures or remedies that may be available. There is no application or processing fee of any kind for an IMR. The Covered Person has the right to provide information in support of the request for an IMR. We must provide the Covered Person with an IMR application form together with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause a Covered Person to forfeit any California statutory right to pursue legal action against us regarding the disputed health care service. It should be noted that we do not believe any such California statutory right exists which is applicable to it.
For more information regarding the IMR process, or to request an application form, please contact us.
Eligibility.
The California Department of Insurance will review the Covered Person's application for an IMR to confirm that:
1. a. The provider has recommended a health care service as Medically Necessary.
b. The Covered Person has received urgent care or emergency services that a provider determined was Medically Necessary; or
c. The Covered Person has been seen by a provider for the diagnosis or treatment of the medical condition for which he or she seeks independent review.
2. The disputed health care service has been denied, modified, or delayed by us based in whole or in part on a decision that the health care service is not Medically Necessary; and
3. The Covered Person filed a grievance with us and the disputed decision is upheld or the grievance remains unresolved after 30 days. If the grievance requires expedited review, the Covered Person may bring it immediately to the attention of the California Department of Insurance. It may waive the requirement that the Covered Person follow the plan's grievance process in extraordinary and compelling cases.
If a case is eligible for an IMR, the dispute will be submitted to a medical specialist who will make an independent determination as to whether or not the care is Medically Necessary. The Covered Person will receive a copy of the assessment made. If the IMR determines the service is Medically Necessary, we will provide benefits for the health care service.
For non-urgent cases the IMR organization designated by the California Department of Insurance must provide its determination within 30 days of receipt of the Covered Person's application and supporting documents. For urgent cases involving imminent and serious threat to a Covered Person's health including, but not limited to, serious pain, the potential loss of life, limb or major bodily function, or the immediate and serious deterioration of the Covered Person's health, the IMR organization must provide its determination within three business days.

IN WITNESS WHEREOF, Arch Insurance Company has caused this certificate to be executed and attested.

Patrick K. Nails
Secretary

John Mentz
President

EMERGENCY ASSISTANCE SERVICES

MEDICAL ASSISTANCE SERVICES

Medical Referral: Referrals will be provided for physicians, hospitals, clinics or any other medical service provider requested by the Insured. Service is available 24 hours a day, worldwide.

Medical Monitoring: In the event the Insured is admitted to a US or foreign hospital, the Assistance Provider will coordinate communication between the Insured's own physician and the attending medical doctor or doctors. The Assistance Provider will monitor the Insured's progress and update the family or the insurance company accordingly.

Prescription Drug Replacement/Shipment: Assistance will be provided in replacing lost, misplaced, or forgotten medication by locating a supplier of the same medication or by arranging for shipment of the medication as soon as possible.

Emergency Message Transmittal: The Assistance Provider will forward an emergency message to and from a family member, friend or medical provider.

Coverage Verification/Payment Assistance for Medical Expenses: The Assistance Provider will provide verification of the Insured's medical insurance coverage when necessary to gain admittance to foreign hospitals, and if requested, and approved by the Insured's insurance company, or with adequate credit guarantees as determined by the Insured, provide a guarantee of payment to the treating facility.

TRAVEL ASSISTANCE SERVICES

Assistance in Obtaining Emergency Cash:

The Assistance Provider will advise how to obtain or to send emergency funds world-wide.

Traveler Check Replacement Assistance: The Assistance Provider will assist in obtaining replacements for lost or stolen traveler checks from any company, i.e.. Visa, Master Card, Cooks, American Express, etc.., worldwide.

Lost/Delayed Luggage Tracing: The Assistance Provider will assist the Insured whose baggage is lost, stolen or delayed while traveling on a common carrier,

Replacement of Lost or Stolen Airline Ticket: One telephone call to the provided 800 number will activate the Assistance Provider's staff in obtaining a replacement ticket.

TECHNICAL ASSISTANCE SERVICES

Credit Card - Passport - Important Document Replacement: The Assistance Provider will assist in the replacement of any lost or stolen important document such as a credit card, passport, visa, medical record, etc.. and have the documents delivered or picked up at the nearest embassy or consulate.

Locating Legal Services: The Assistance Provider will help the Insured contact a local attorney or the appropriate consular officer when an Insured is arrested or detained, is in an automobile accident, or otherwise needs legal help. The Assistance provider will maintain communications with the Insured, family, and business associates until legal counsel has been retained by or for the Insured.

Assistance in Posting Bond/Bail: Assist by providing a referral to a bail bondsman. The Assistance Provider will arrange for the bail bondsman to contact the Insured or to visit at the jail if incarcerated.

Worldwide Inoculation Information: Information will be provided if requested by an Insured for all required inoculations relative to the area of the world being visited as well as any other pertinent medical information.

EMERGENCY MEDICAL EVACUATION AND RETURN OF MORTAL REMAINS

Emergency Medical Evacuation

The Company will pay, subject to the limitations set out herein, for Covered Emergency Evacuation Expenses reasonably incurred, a) if the Covered Person suffers an Injury or Emergency Sickness that warrants his or her Emergency Evacuation while traveling during the company's sponsored trip or b) after being treated at a local medical facility, once stabilized, if the Covered Person's medical condition warrants transportation with a qualified medical attendant to his/her Home Country. Emergency Evacuation eligible expenses are payable subject to the Maximum Amount per Covered Person listed on the Table for all Emergency Evacuations due to all Injuries from the same Accident or all Emergency Sicknesses from the same or related causes.

A legally licensed Physician, in coordination with the Assistance Service Provider, must order the Emergency Evacuation and must certify that the severity of the Covered Person's Injury or Emergency Sickness warrants his or her Emergency Evacuation to the closest adequate medical facility. It must be determined that such Emergency Evacuation is required due to the inadequacy of local facilities.

The certification and approval for Emergency Evacuation must be coordinated through the most direct and economical conveyance and route possible, such as air or land ambulance, or commercial airline carrier.

Covered Emergency Evacuation Expenses are those for Medically Necessary Transportation, including reasonable and customary medical services and supplies incurred in connection with the Emergency Evacuation of the Covered Person. Expenses for Transportation must be: (a) recommended by the attending Physician; and (b) required by the standard regulations of the conveyance transporting the Covered Person; and (c) reviewed and pre-approved by the Assistance Service Provider.

Return of Mortal Remains

The Company will pay the reasonable Covered Expenses incurred to return the Covered Person's body to their primary residence if he/she dies while traveling during the company's sponsored trip. This will not exceed the Return of Mortal Remains maximum listed in the Table.

Covered Expenses include, but are not limited to, expenses for embalming, cremation, casket for transport and transportation.

All Covered Expenses in connection with a return of mortal remains must be pre-approved and arranged by Our Assistance Service Provider.

EMERGENCY MEDICAL EVACUATION / RETURN OF MORTAL REMAINS

DEFINITIONS:

Appropriate Authority(ies) means the government authority(ies) in the Covered Person's Home Country or the government authority(ies) of the Host Country.

Assistance Service Provider means Assist America, Inc. (AAI)

Covered Expenses mean expenses which are for Medically Necessary services, supplies, care, or Treatment; due to Illness or Injury; prescribed, performed or ordered by a Physician; reasonable and customary charges; incurred while covered; and which do not exceed the maximum amounts listed in the Table.

Covered Person means an eligible person who is within the covered class(es) listed in the Policy, and for whom the required premium is paid when due.

Designated Security Consultant means an employee of a security firm under contract to AAI or an AAI designated service provider who is experienced in security and measures necessary to ensure the safety of the Covered Person(s) in his or her care.

Emergency Evacuation means the Covered Person's medical condition warrants immediate transportation from the place where the Covered Person is injured or sick to the nearest hospital where appropriate medical treatment can be obtained.

Emergency Sickness means an illness or disease, diagnosed by a legally licensed Physician, which meets all of the following criteria: (1) there is a present severe or acute symptom requiring immediate care and the failure to obtain such care could reasonably result in serious deterioration of the Covered Person's condition or place his or her life in jeopardy; (2) the severe or acute symptom occurs suddenly and unexpectedly; and (3) the severe or acute symptom occurs while coverage is in force while the Covered Person suffers the symptom.

Excluded Countries means the following countries from which Security Evacuations are not available including any country subject to the administration and enforcement of U. S. economic embargoes and trade sanctions by the Office of Foreign Assets Control (OFAC).

Home Country means the country of citizenship of the Covered Person. If the Covered Person has dual citizenship, for the purposes of this benefit, his or her Home Country is the country of the passport he or she used to enter the Host Country.

Host Country means any country, other than an Excluded Country, in which a Covered Person is traveling during the company's sponsored trip.

Injury means accidental bodily injury or injuries caused by an accident. The Injury must be the direct cause of the loss, independent of disease, bodily infirmity or other causes.

Physician means a doctor of medicine or a doctor of osteopathy licensed to render medical services or perform Surgery in accordance with the laws of the jurisdiction where such professional services are performed, however, such definition will exclude chiropractors and physiotherapists.

Transport/Transportation means the most efficient and available method of conveyance. In all cases, where practical, economy fare will be utilized. If possible, the Covered Person's common carrier tickets will be used.

EXCLUSIONS:

No benefits are payable for charges, fees or expenses:

1. That are recoverable through the Covered Person's employer;
2. Arising from or attributable to an actual fraudulent, dishonest or criminal act committed or attempted by a Covered Person, acting alone or in collusion with others;
3. Arising from or attributable to an alleged:
   - Violation of the laws of the Host country by a Covered Person;
   - Violation of the laws of the Covered Person's Home Country unless the Designated Security Consultant determines that such allegations were intentionally false, fraudulent and malicious and made solely to achieve a political, propaganda and/or coercive effect upon or at the expense of the Covered Person;
4. Due to the Covered Person's failure to maintain and possess duly authorized and issued required travel documents and visas;
5. Arising from an Occurrence which took place in an Excluded Country;
6. For common or endemic or epidemic diseases or global pandemic disease as defined by the World Health Organization;
7. For medical services;

Arising from or attributable, in whole or part, to a debt, insolvency, commercial failure, the repossession of any property by any title holder or lien holder or any other financial cause.

Table: Maximum Amount per Covered Person

Emergency Medical Evacuation	100% of Covered Expenses
Return of Mortal Remains (Repatriation)	100% of Covered Expenses

California Guaranty Notice

NOTICE OF PROTECTION PROVIDED BY THE CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protection provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. Insurance Companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The valuable extra protection provided through the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and he amounts of coverage.

Below is a brief summary of the coverages, exclusions, and limit provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the California Life and Health Insurance Guarantee Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows:

Life Insurance, Annuities and Structured Settlement Annuity Benefits

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- **Life Insurance**

80% of death benefits but not to exceed $300,000
80% of cash surrender or withdrawal values but not to exceed $100,000

- **Annuities and Structured Settlement Annuities**

80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000.

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of polices or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of April 1, 2011, is $470,125. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The California Life and Health Insurance Guarantee Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract;
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;
- If the person is provided coverage by the guaranty association of another state;
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual;
- Employer and association plans, to the extent they are self-funded or uninsured;
- A policy or contract providing any health care benefits under Medicare Part C or Part D;
- An annuity issued by an organization that is only licensed to issue charitable gift annuities;
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract;
- Any policy of reinsurance unless an assumption certificate was issued;
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b) (C)

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance Guarantee Association
P.O. Box 16860
Beverly Hills, CA 90209-3319
(323) 782-0182

or

Consumer Service Division
California Department of Insurance
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357 or (213) 897-8921

Insurance companies and their agents are not allowed by California law to use the existence of the Guarantee Association or its coverage to solicit, induce or encourage you to purchase any form of insurance policy. When selecting an insurance company, you should not rely on Association coverage. If there is an inconsistency between this notice and California law, then California law will control.

PRIVACY POLICY AND PRACTICES OF
ARCH INSURANCE COMPANY (ARCH)

Insurance companies must collect a certain amount of nonpublic personal information to serve customers and administer business. ARCH values your trust and is committed to the responsible management, use and protection of your nonpublic personal information. This notice describes our policy regarding the collection and disclosure of nonpublic personal information.

What is nonpublic personal information?

Nonpublic personal information, as used in this notice, means information that identifies an individual personally and is not otherwise available to the public. It includes information such as credit history, income, financial benefits, policy or claim information. It also includes personal health information such as individual medical records or information about an illness, disability, or injury.

Why does ARCH collect nonpublic personal information?

ARCH collects nonpublic personal information to support our normal business operations. We may obtain nonpublic personal information directly from you or from other parties, such as a consumer reporting agency. Personal information such as a name, address, income, payment history or credit history is gathered from sources such as applications, transactions and consumer reports.

With whom might ARCH share your nonpublic personal information?

We only disclose nonpublic personal information about you as permitted or as required by law. ARCH's employees have access to nonpublic personal information in the course of doing their jobs which includes underwriting policies, paying claims, developing new products or advising customers of our products and services. ARCH may share nonpublic personal financial information with our affiliates, such as insurance companies, agents, brokerage firms and administrators.

ARCH may also share information with unaffiliated third parties, including agents, brokerage firms, insurance companies, administrators and other service providers. We may also disclose nonpublic personal information as required by law. We may disclose personal health information with proper written authorization or as otherwise permitted or required by law.

What does ARCH do to make sure that nonpublic personal information is secure and confidential?

ARCH uses manual and electronic security procedures to maintain the confidentiality of personal information in our possession and guard against unauthorized access. Some techniques we employ to protect information include locked files, user authentication, firewall technology, and the use of detection software.

ARCH is responsible for identifying information that must be protected, providing an adequate level of protection for that data and granting access to protected data only to individuals who must use it in the performance of their job-related duties.

Does ARCH maintain confidentiality of nonpublic personal information after a policy expires?

ARCH will continue to follow this policy regarding nonpublic personal information even when you are no longer our customer.

We reserve the right to change our privacy policy. You will receive a notice of any such change.

ARCH INSURANCE COMPANY
(A Missouri Corporation)

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

POLICYHOLDER	**County of San Bernardino**
POLICY NUMBER	**11BTA0934000**
POLICY TERM	**July 1, 2019 TO June 30, 2022**
ENDORSEMENT NUMBER	1
ENDORSEMENT EFFECTIVE DATE	**July 1, 2019**

This Endorsement is made a part of the Policy to which it is attached as of the Effective Date shown above.
This form applies only to Covered Accidents that occur on or after the Effective Date. This Endorsement ends at the same time as the Policy. This Endorsement is subject to all of the provisions, terms and limitations of the Policy, except as they are changed by it.

It is hereby agreed and understood that effective with this Endorsement Effective Date, the following changes are made to the Policy:

SECTION I – SCHEDULE OF BENEFITS
ADDITIONAL ACCIDENT BENEFITS
Class 1 and 2

Maximum Benefit amounts for the following benefits have been revised.

Carjacking Benefit	10% of the Covered Person's Principal Sum up to a Maximum Benefit of **$25,000**
Child Care Center Benefit	
Benefit Amount	**$10,000**
Maximum Benefit Period	to age 13
Seatbelt And Airbag Benefit	
Seatbelt Benefit	10% of the Covered Person's Principal Sum up to a Maximum Benefit of **$25,000**
Airbag Benefit	10% of the Covered Person's Principal Sum up to a Maximum Benefit of **$25,000**

The following Additional Accident Benefit has been added:

Return of Minor Children Benefit	
Benefit Maximum:	$5,000

SECTION VII – DESCRIPTION OF BENEFITS
ADDITIONAL ACCIDENT BENEFITS

The following Additional Accident Benefit description has been added:

Return of Minor Child(ren) Benefit
If the Insured, age 18 or older, is the only person traveling with minor Dependent children who are under the age of 18, and such Insured suffers an Injury and must be confined in a Hospital, or if the Insured is medically evacuated to another location, We will reimburse the cost of a one way economy airfare ticket or ground transportation ticket to return each minor Dependent child to his or her Home Country or principal residence; not to exceed the Benefit Maximum shown in the Schedule of Benefits. All transportation arrangements must be made by the most direct and economical route and Conveyance possible and may not exceed the usual level of charges for similar transportation in the locality where the expense is incurred.
Benefits will not be paid unless all expenses are approved in advance by Us, and services are rendered by the Company's assistance provider.

All other terms and conditions of this Policy remain unchanged.

IN WITNESS WHEREOF, Arch Insurance Company has caused this Endorsement to be executed and attested.

Patrick K. Nails
Secretary

John Mentz
President