Group Accident Insurance Certificate

ZURICH AMERICAN INSURANCE COMPANY
1400 American Lane
Schaumburg, Illinois 60196

This is a summary of the accident insurance **We** provide on behalf of the **Policyholder** to **You** if **You** are within a class of eligible persons described in Section I - Schedule of Benefits and Coverages and if the required premiums are paid when due.

The insurance Policy under which this Certificate is issued is not a policy of Workers' Compensation insurance. You should consult Your employer to determine whether Your employer is a subscriber to the Worker's Compensation system.

THE INSURANCE EVIDENCED BY THIS CERTIFICATE PROVIDES ACCIDENT COVERAGE ONLY

THIS IS A SUMMARY OF COVERAGE ONLY WHICH SUMMARIZES AND EXPLAINS THE PARTS OF THE POLICY WHICH APPLY TO YOU.

FOR ALL TERMS AND CONDITIONS OF COVERAGE, PLEASE REVIEW THE POLICY ISSUED TO THE POLICYHOLDER AND ON FILE WITH THEM AT THEIR PLACE OF BUSINESS. YOU CAN OBTAIN A COPY OF THE POLICY FROM THE POLICYHOLDER.

THIS CERTIFICATE IS NOT AN INSURANCE POLICY. IN THE EVENT OF A CONFLICT OF PROVISIONS BETWEEN THE POLICY AND THIS CERTIFICATE, THE PROVISIONS OF THE POLICY WILL GOVERN

.PLEASE READ THIS CERTIFICATE CAREFULLY

NON-PARTICIPATING

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Zurich's toll-free telephone number for information or to make a complaint at:

1-800-382-2150

You may write to Zurich at:

Zurich in North America
Customer Inquiry Center
1400 American Lane
Schaumburg, Illinois 60196

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, TX 78714-9104
FAX No. (512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:
Should you have a dispute concerning your premium or about a claim you should contact Zurich first. If the dispute is not resolved you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:
This notice is for information only and does not become a part or condition of this Certificate.

AVISO IMPORTANTE

Para obtener información o para someter una queja:

Usted puede llamar al número de teléfono gratis de Zurich para información o para someter una queja al:

1-800-382-2150

Usted puede escribir a Zurich en:

Zurich in North America
Customer Inquiry Center
1400 American Lane
Schaumburg, Illinois 60196

Puede comunicarse con el Departamento de Seguros de Texas para obtener la información acerca de compañías, coberturas, derechos, o quejas de:

1-800-252-3439

Usted escribir al Departamento de Seguro de Texas:

P.O. Box 149104
Austin, TX 78714-9104
FAX No. (512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS:
Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el Zurich primero. Si no se resuelta la disputa, puede entonces comunicarse con el departamento (Texas Department of Insurance).

UNA ESTE AVISO A SU POLIZA:
Este aviso es solo para proposito de información y no se convierte en parte o condición del document adjunto.

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SECTION I - SCHEDULE

I. **POLICYHOLDER**: National Association of Consumer Direct
2841 S. Ingram Mill Road, Suite A100
Springfield, MO 65804

II. POLICY NUMBER: MCB 4380419

III. POLICY INCEPTION DATE: November 1, 2010

IV. POLICY PERIOD: November 1, 2010 to Continuous
(All Insurance begins and ends at 12:01 a.m. at the **Policyholder's** address)

V. PREMIUM: Class: Per Enrollment Form

VI. ELIGIBILITY AND CLASSIFICATION OF INSUREDS:

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

Class: Per Enrollment Form

If a **Covered Person** 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. **PRINCIPAL SUM**:

Class: Per Enrollment Form

The **Principal Sum** for covered **Dependents** will be a percentage of the **Insured's Principal Sum**, on the date of **Accident**, determined by multiplying **Your Principal Sum** by the percentage below.

Plan Selected	% Spouse/Domestic Partner	% Child(ren)
Spouse/Domestic Partner only:	50%	0
Dependent Child(ren) only:	0	15%
Spouse/Domestic Partner and **Dependent Child(ren)**;	40%	10%

VIII. COVERAGES:

COVERAGE	CLASS COVERED	COVERAGE AMOUNT	
Accidental Death and Dismemberment Coverage	All	Accidental Death	100% of **Principal Sum**
		Loss of:	
		1. Both Hands or Both Feet	100% of **Principal Sum**
		2. One Hand and One Foot	100% of **Principal Sum**
		3. One Hand or One Foot plus the loss of Sight of One Eye	100% of **Principal Sum**
		4. Sight of Both Eyes	100% of **Principal Sum**
		5. Speech and Hearing	100% of **Principal Sum**
		6. Speech or Hearing	50% of **Principal Sum**
		7. One Hand; One Foot; or Sight of One Eye	50% of **Principal Sum**
		8. Thumb and Index Finger of the same Hand	25% of **Principal Sum**
		9. Hearing in One Ear	25% of **Principal Sum**
Exposure and Disappearance Coverage	All	100% of **Principal Sum**	

IX. BENEFIT RIDER:

BENEFIT	CLASS COVERED	BENEFIT AMOUNT	FORM NUMBER
Accident Medical Expense	All	See Benefit Rider	U-GMC-138-AS-A TX

X. REPORTING AND NOTICE ADDRESSES:

Claim Reporting:
Claims Department
Zurich American Insurance Company,
P.O. Box 968041, Schaumburg, IL. 60196
1-877-287-4805

SECTION II – ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE

ELIGIBILITY OF INSURED'S DEPENDENTS

You may elect to cover **Your** eligible **Dependents**. An eligible **Dependent** includes **Your Spouse/Domestic Partner** and **Your Dependent Child(ren)**, and **Your Spouse's Dependent Child(ren)**, and **Your Domestic Partner's Dependent Child(ren)**. A **Spouse/Domestic Partner** will not be eligible as a **Dependent** if he or she is also an **Insured** under the **Policy**. If **You** and **Your Spouse/Domestic Partner**, or former **Spouse/Domestic Partner** are both **Insured's** under the **Policy**, only one may select a **Plan** covering **Your** mutual **Dependents**.

INSURED'S EFFECTIVE DATE

Your coverage under the **Policy** begins on the latest of:

1. the Policy Inception Date shown in the Schedule;
2. the date for which the first premium for **Your** coverage is paid;
3. the date **You** become a member of an eligible class of persons as described in the Eligibility and Classification of Insureds section of the **Policy**; or
4. A. For individuals eligible on November 1, 2010: provided the completed enrollment material is received by **Us** on or prior thereto.

   B. For individuals eligible on or after November 1, 2010: on the first day of the month following the date the completed enrollment material is received by **Us**.

A change in **Your** coverage under the **Policy** due to a change in **Your** eligible class becomes effective on the later of:

1. when the change in **Your** eligible class occurs; or
2. if the change requires a change in premium, the date the first changed premium is paid.

However, a change in coverage applies only with respect to **Accidents** that occur after the change becomes effective.

ELIGIBLE DEPENDENTS EFFECTIVE DATE

An eligible **Dependent's** coverage under the **Policy** begins on the latest of:

1. the Policy Inception Date shown in the Schedule;
2. **Your** Effective Date;
3. the date for which the first premium for the **Dependent's** coverage is paid;
4. the date the person qualifies as a **Dependent**; or
5. the date on which written enrollment for the **Dependent** is received by **Us**.

Your child born while the **Policy** is in force is covered from the moment of birth for a period of 31 days. After this time, **Your** child will remain covered only if **You** have provided written notice of birth to the **Policyholder** and pays the required premium due, if any.

Your newly adopted child is covered from the moment of adoption or placement for adoption, for a period of 31 days. After this time, **Your** child will remain covered only if **You** have provided written notice to the **Policyholder** of the adoption or placement for adoption, and pay the required premium due, if any.

SECTION III – DEFINITIONS

Accident or **Accidental** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place during the **Policy** term.

Active means a member as defined by the Policyholder based on elements relating to the relationship between the organization and its members, the school and its students, the creditor and its debtors, or the vendor and its vendees, etc.

Active Member means a member in good standing according to the rules of the **Policyholder**.

Certificate means this Group Accident Insurance Certificate.

Covered Accident means an **Accident** that results in a **Covered Loss**.

Covered Injury means bodily injury directly caused by **Accidental** means which is independent of all other causes, results from a **Covered Accident**, occurs while the **Covered Person** is insured under the **Policy**, and results in a **Covered Loss**.

Covered Loss means a loss which meets the requisites of one or more benefits or additional benefits, results from a **Covered Injury**, and for which benefits are payable under the **Policy**.

Covered Person means any person who has insurance under the terms of the **Policy**. It includes **You**, and **Your Spouse/Domestic Partner** and/or **Dependent Child(ren)** if a **Plan** covering **Your Spouse/Domestic Partner** and/or **Dependent Child(ren)** is selected.

Dependent means **Your Spouse**/**Domestic Partner** and **Dependent Child(ren)**, as defined in this section. **Your Dependent** will only be a covered **Dependent** if a **Plan** covering **Dependents** is selected.

Dependent Child(ren) means **Your** unmarried **Child(ren)**, and those unmarried **Child(ren)** of **Your Spouse**/**Domestic Partner** who are less than 25 (twenty-five) years of age, including **Your** or **Your Spouse's/Domestic Partner's** unmarried legally adopted **Childr(ren)**, unmarried grandchild(ren) if at the time of application for insurance **Your** or **Your Spouse's/Domestic Partner's** grandchild(ren) are **Dependent Child(ren)** for federal income tax purposes, and unmarried **Child(ren)** for whom a court order or medical support order requires **You** or **Your Spouse/Domestic Partner** to provide coverage, and those unmarried **Child(ren)** as defined in the **Policyholder's** medical plan as on file and approved by **Us** who are less than 25 (twenty-five) years of age and are chiefly dependent on **You** for their support and maintenance, and who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental or physical disability. **Your Dependent Child(ren)** will only be covered **Dependent Child(ren)** if a **Plan** covering **Dependent Child(ren)** is selected.

Domestic Partner means a person who qualifies as a **Domestic Partner** under the **Policyholder's** written procedures as on file and approved by **Us**.

To qualify as a **Domestic Partner**, the following requirements must be met:

1. **You** and **Your Domestic Partner** must have an intimate, committed relationship of mutual caring, and have agreed to be responsible for each other's welfare;
2. **You** and **Your Domestic Partner** must have lived together in such a relationship for a period of not less than six consecutive months at the same residence address;
3. **You** and **Your Domestic Partner** must both be at least 18 years of age;
4. neither **You** nor **Your Domestic Partner** are legally married;
5. **You** and **Your Domestic Partner** are not **Related** by blood or adoption;
6. **You** and **Your Domestic Partner** are each other's sole **Domestic Partner** and intend to remain so indefinitely; and
7. **You** and **Your Domestic Partner** must be of the same sex, and if applicable law permitted, would be married.

The existence of the relationship between **Your Domestic Partner** and **You** must be evidenced by:

1. **Your Domestic Partner** being named as the primary beneficiary in the event of **Your** death under **Your** retirement plan or 401(k) plan, if **You** maintain such a plan;
2. at least one of the following:
   a. designation of **Your Domestic Partner** as a primary beneficiary under **Your** will; or
   b. designation of **Your Domestic Partner** as a primary beneficiary for **Your** life insurance;
3. at least one of the following:
   a. joint ownership of real estate (whether by mortgage, lease or deed);
   b. joint ownership of a motor vehicle; or
   c. joint ownership of a bank account; and
4. a completed, active certification of **Domestic Partner** status form on file with the **Policyholder**.

To be active, **You** will not have completed a Termination of **Domestic Partner** status form with respect to **Your Domestic Partner** who is to be covered under the **Policy**.

Foreign National means a person who is a citizen of a country or other jurisdiction other than the United States of America and who is not a resident of the United States of America.

Insured means an individual who is eligible for coverage under the **Policy** as provided in the Eligibility and Classification of Insureds part of the Schedule, and who completes the enrollment material, if required.

Non-Contributory means that the premium payments require no contribution from **You**.

Physician means a person who is:

1. a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that **We** recognize or are required by law to recognize;
2. licensed to practice in the jurisdiction where care is being given;
3. practicing within the scope of that license; and
4. not **Related** to **You** by blood or marriage.

Plan means the coverages and/or benefits selected in the Schedule.

Policy means the Group Accident Insurance Policy issued to the **Policyholder**.

Policyholder means the group named in the Schedule.

Principal Sum means the amount of insurance applicable to the **Insured** or **Covered Person** as stated in the Schedule.

Related means **Your Spouse**/**Domestic Partner** or other adult living with **You**, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.

Sponsor means **Policyholder**.

Spouse means **Your** legally married **Spouse**. A **Spouse** will only be a covered **Spouse** if a **Plan** covering **Your Spouse** is selected.

We, **Us**, and **Our** refers to Zurich American Insurance Company or **Our** authorized representative.

You or **Your** means the **Insured** to whom a **Certificate** is issued.

SECTION IV – GENERAL EXCLUSIONS

A loss will not be a **Covered Loss** if it is caused by, contributed to, or results from:

1. suicide or any attempt at suicide or intentionally self-inflicted **Covered Injury** or any attempt at intentionally self-inflicted injury.
2. war or any act of war, whether declared or undeclared.
3. involvement in any type of active military service.

4. illness or disease, regardless of how contracted, medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; except for **Accidental** ingestion of contaminated foods.
5. participation in the commission or attempted commission of a crime, any felony, an assault, insurrection or riot.
6. being intoxicated.
   a. A **Covered Person** will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.
   b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the **Covered Person's** intoxication.
7. being under the influence of any prescription drug, controlled substance, or hallucinogen, unless such prescription drug, controlled substance, or hallucinogen was prescribed by a **Physician** and taken in accordance with the prescribed dosage.
8. travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight.
9. release, whether or not **Accidental**, or by any person unlawfully or intentionally, of nuclear energy or radiation, including sickness or disease resulting from such release.
10. a cardiovascular event or stroke caused by exertion prior to or at the same time as an **Accident**.
11. any condition for which the **Insured** is entitled to benefits under any Workers' Compensation Act, No Fault Auto Coverage or similar law.

SECTION V – GENERAL LIMITATIONS

Limitation on Multiple Covered Losses. If a **Covered Person** suffers more than one **Covered Loss** as a result of the same **Accident**, **We** will pay only one benefit, the largest benefit.

Limitation on Multiple Coverages and Benefits. If a **Covered Person** can recover benefits under more than one of the Coverages or Benefits as stated in the Schedule,as a result of the same **Accident**, the most **We** will pay for these benefits in total is the **Covered Person's Principal Sum**.

SECTION VI – PREMIUMS

A. Premiums. Premiums are due and payable to **Us** at the rates and in the manner described in the Schedule.

B. Grace Period. Premiums are due on or before the premium due date or renewal date, whichever applies. If **You** do not pay premium when it is due, there is a thirty-one (31) day Grace Period to pay. During the Grace Period, **Your** coverage under the **Policy** will stay in force.

SECTION VII - TERMINATION OF INSURANCE

A. Termination of **Covered Person's** Insurance.

Insured. Insurance terminates at the end of the month for which premium has been paid and during which any of the following occurs:

1. the **Policy** is terminated;
2. **You** cease to be eligible for insurance;
3. **You** fail to pay the required premium, if **You** are so required;

Covered Person other than the **Insured**. Insurance terminates on the earliest of:

1. the date **Your** insurance terminates;
2. the first premium due date after the person no longer qualifies as a **Covered Person**;

SECTION VIII - HOW TO FILE A CLAIM

A. Notice. **You** or **Your** beneficiary, or someone on **Your** behalf, must give **Us** written notice of the **Covered Loss** within ninety (90) days of such **Covered Loss**, or as soon thereafter as reasonably possible. The notice must name the **Covered Person** who sustained the injury, **You**, and the Policy Number. To request a claim form, **You** or **Your** beneficiary, or someone on **Your** behalf may contact **Us** at 1/877-287-4805. The notice must be sent to the address shown on the Schedule, or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.

B. Claim Forms. **We** will send the claimant Proof of Covered Loss forms within fifteen (15) days after **We** receive notice. If the claimant does not receive the Proof of Covered Loss form in fifteen (15) days after submitting notice, he or she can send **Us** a detailed written report of the claim and the extent of the **Covered Loss**. **We** will accept this report as a Proof of Covered Loss if sent within the time fixed below for filing a Proof of Covered Loss.

C. Proof of Covered Loss. Written Proof of Covered Loss, acceptable to **Us**, must be sent within ninety (90) days of the **Covered Loss**. Failure to furnish Proof of Covered Loss acceptable to **Us** within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the Proof of Covered Loss**,** and the proof was provided as soon as reasonably possible, but (except in case of the absence of legal capacity of the claimant) no later than one (1) year from the time proof is otherwise required under the **Policy**.

SECTION IX - PAYMENT OF CLAIMS

A. Time of Payment. **We** will pay claims for all **Covered Losses**, other than **Covered Losses** for which the **Policy** provides any periodic payment, immediately upon receipt of written proof of loss that is acceptable to **Us**. Unless an optional periodic payment is stated or chosen, any **Covered Loss** to be paid in periodic payments will be paid at the end of each four-week period. The unpaid balance, which remains when **Our** liability ends, will then be paid when **We** receive the Proof of Covered Loss that is acceptable to **Us**.

B. Who We Will Pay.

1. Loss of **Your** life. **Covered Losses** resulting from **Your** death are paid to the named beneficiary at the time of death. If there is no beneficiary named or the named beneficiary predeceases or dies at the same time as **You**, **We** will pay the benefit to the beneficiary named by **You** for **Your** Life Insurance policy. If there is no beneficiary named by **You** for **Your** Life Insurance policy, or the named beneficiary predeceases or dies at the same time as **You**, **We** will pay the benefit to **Your** survivors in the following order:

   a. **Your Spouse**/**Domestic Partner**;

   b. **Your** child(ren);

   c. **Your** parents;

   d. **Your** brothers and sisters;

   e. **Your** estate.

2. All Other Claims. Benefits are to be paid to the **Covered Person**. The **Covered Person** may direct in writing that all, or part of the **Accident Medical Expense Benefit**, if applicable, will be paid directly to the party who furnished the service. The direction may be changed by the **Covered Person** at any time up to the filing of the Proof of Covered Loss.

3. If a **Foreign National** is entitled to benefits for a **Covered Loss** and **We** are unable to make payment directly to him or her because of legal restrictions in the country or jurisdiction where such **Foreign National** is located, **We** will either: (1) pay the benefits to a bank account owned by the **Foreign National** in the United States of America; or (2) if no such bank account is established or maintained, **We** will pay the benefits to the **Policyholder** on behalf of the **Foreign National**. It will then be the responsibility of the **Policyholder** to remit the benefit to such **Foreign National**. Payment of the benefit to the **Policyholder** will release **Us** from any further liability to the **Foreign National**. If the **Policyholder** does not remit the payment to the **Foreign National**, the **Policyholder** will indemnify **Us** and hold **Us** harmless against any and all liability incurred by **Us** including, but not limited to, interest, penalties, and attorneys' fees in connection with, arising or resulting from such failure to remit payment. The **Policyholder** will not be considered the beneficiary under the **Policy** if payment is made to the **Policyholder** in accordance with this provision.

4. Any payment **We** make will fully discharge **Us** to the extent of the payment.

C. Payment of Benefits to the Texas Department of Human Services. All benefits paid on behalf of **Your** or **Your Spouse's**[**/Domestic Partner's**] **Dependent Child(ren)** under the **Policy** must be paid to the Texas Department of Human Services whenever:

1. The Texas Department of Human Services is paying under the Human Resources Code, Chapter 31 or 32, which is the financial and medical assistance service program administered pursuant to the Human Resources Code; and
2. The parent who purchased the **Policy** has possession or access to the **Dependent Child(ren)** pursuant to a court order, or is not entitled to access or possession and is required to pay child support; and
3. **We** receive written notice affixed to the insurance claim, when the claim is first submitted, which states that all benefits paid pursuant to this provision must be paid directly to the Texas Department of Human Services.

SECTION X - GENERAL POLICY CONDITIONS

A. Beneficiaries. **You** have the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. Unless an irrevocable beneficiary is named, **You** may change the beneficiary at any time unless he or she has assigned the interest in the **Policy**. In such case, the person to whom he or she has assigned the interest in the **Policy** may have the right to change the beneficiary. Consent to a change by a prior beneficiary is not needed. Any beneficiary designation must be in writing on a form acceptable to **Us.**

B. Change or Waiver. A change or waiver of any terms or conditions of the **Policy** must be issued by **Us** in writing and signed by one of **Our** executive officers. No agent has authority to change or waive **Policy** terms or conditions. A failure to exercise any of **Our** rights under the **Policy** will not be deemed as a waiver of such rights in the same or future situations.

C. Clerical Error. A clerical error or omission will not increase or continue **Your** coverage, which otherwise would not be in force. If **You** apply for insurance for which **You** are not eligible, **We** will only be liable for any premiums paid to **Us**.

D. Suit Against Us. No action on the **Policy** may be brought until sixty (60) days after written Proof of Covered Loss has been sent to **Us**. Any action must commence within three (3) years, (five (5) years in Kansas and Tennessee; and six (6) years in South Carolina and Wisconsin) of the date the written Proof of Covered Loss was required to be submitted. If the law of the state where the **Covered Person** lives makes such limit void, then the action must begin within the shortest time period permitted by law. In those states where binding arbitration is allowed, binding arbitration will supersede this provision.

E. Physical Examination and Autopsy. **We** have the right to examine a **Covered Person** when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** can have an autopsy performed unless forbidden by law.

F. Choice of Service Provider. The **Covered Person** has the sole right to choose his or her duly licensed **Physician** and hospital.

G. Arbitration. Any contest to a claim denial under the **Policy** will be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration will occur at the offices of the American Arbitration Association nearest to the **Covered Person**. The arbitrator(s) will not award consequential or punitive damages in any arbitration under this section. This provision does not apply if the **Covered Person** is a resident of a state where the law does not allow binding arbitration in an insurance **Policy**, but only if the **Policy** is subject to its laws. In such a case, binding arbitration does not apply. This provision bars the institution of lawsuit by the **Covered Person**.

H. Time Limit on Certain Defenses. In the absence of fraud, statements made by the **Policyholder** or a **Covered Person** are deemed representations and not warranties. No such statement will cause **Us** to deny or reduce the benefits due under the **Policy** or be used as a defense of a claim, unless it is contained in a signed written application. After two years from the date coverage starts no such statement will cause the **Policy** to be contested.

I. Misstatement of Age. If the age of the **Covered Person** has been misstated, **We** will adjust the benefits under the **Policy** to those that would be applicable at the correct age.

SECTION XI – COVERAGES

ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE

If a **Covered Person** suffers a loss of life as a result of a **Covered Injury**, **We** will pay the applicable **Principal Sum**. The death must occur within 365 days of the **Covered Injury**.

If a **Covered Injury** to a **Covered Person** results in any of the following **Covered Losses**, **We** will pay the benefit amount shown. The **Covered Loss** must occur within 365 days of the **Accident**.

The benefit amounts are based on the **Principal Sum** of the person suffering the **Covered Loss**.

Covered Loss of	**Benefit**
1. Both Hands or Both Feet	100% of **Principal Sum**
2. One Hand and One Foot	100% of **Principal Sum**
3. One Hand or One Foot plus the loss of Sight of One Eye	100% of **Principal Sum**
4. Sight of Both Eyes	100% of **Principal Sum**
5. Speech and Hearing	100% of **Principal Sum**
6. Speech or Hearing	50% of **Principal Sum**
7. One Hand; One Foot; or Sight of One Eye	50% of **Principal Sum**
8. Thumb and Index Finger of the same Hand	25% of **Principal Sum**
9. Hearing in One Ear	25% of **Principal Sum**

For purposes of this benefit:

Covered Loss means:

1. For a foot or hand, actual severance through or above an ankle or wrist joint;
2. Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
3. Total and permanent loss of sight;
4. Total and permanent loss of speech; or
5. Total and permanent loss of hearing.

EXPOSURE AND DISAPPEARANCE COVERAGE

If a **Covered Person** is exposed to weather because of an **Accident** and this results in a **Covered Loss**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

If the conveyance in which a **Covered Person** is riding disappears, is wrecked, or sinks, and the **Covered Person** is not found within 365 days of the event, **We** will presume that the person lost his or her life as a result of injury. If travel in such conveyance was covered under the terms of the **Policy**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms. **We** have the right to recover the benefit if **We** find that the **Covered Person** survived the event.

Accident Medical Expense Benefit

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 Group Accident Policy/Certificate.

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

Accident Medical Expense Schedule		
Benefit	Maximum Benefit per **Covered Person** per **Covered Accident**	Deductible per **Covered Person** per **Covered Accident**
Accident Medical	Per Enrollment Form	Per Enrollment Form

We will pay the **Usual and Customary** expenses for **Medically Necessary Covered Medical Service(s)** incurred by the **Covered Person** resulting from a **Covered Accident**, 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 within fifty-two (52) weeks of the **Covered Injury.**

For the purposes of this rider 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 a **Covered Person** 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 through the same incision, **We** will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session but through different incisions, **We** will pay for the most expensive procedure.
8. Assistant physician expenses when **Medically Necessary**.
9. The services of a registered nurse when **Medically Necessary** (not **Related** to the **Covered Person**).
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, message 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** (excluding air ambulance).
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 a **Covered Person**. **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 **Covered Person**;
2. related to performing, or assisting the **Covered Person** 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;
3. that are not required to be performed by trained or skilled medical personnel;
4. that are prescribed by a Physician; and
5. that are provided by persons not **Related** to the **Covered Person**.

Hospital means an institution which:

1. operates pursuant to law;
2. primarily and continuously provides medical care and treatment to sick and injured persons on an inpatient basis;
3. operates facilities for medical and surgical diagnosis and treatment by or under the supervision of **Physicians**; and
4. provides 24-hour nursing service by or under the supervision of graduate registered nurses (R.N.).

Hospital does not mean any institution or part thereof which is used primarily as:

1. a nursing home, convalescent home, or skilled nursing facility;
2. a place of rest, custodial care, or for the aged;
3. a clinic; or
4. a place for the treatment of mental illness, alcoholism or substance abuse.

However, a place for the treatment of mental illness, alcoholism or substance abuse will be regarded as a **Hospital** if it is:

1. part of the institution that meets the above requirements; and
2. listed in the American Hospital Association Guide as a general **Hospital**.

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

Medically Necessary means that the medical service or treatment:

1. is essential for the diagnosis, treatment or care of the **Covered Injury** for which it is prescribed or performed;
2. meets generally accepted standards of medical practice; and
3. is ordered by a **Physician**.

Medical Repatriation means transporting a **Covered Person** back to his or principal residence or to the country where he or she was assigned due to the **Covered Person** being injured.

Pre-existing Condition means a condition for which a **Covered Person** received any diagnosis, medical advice or treatment or had taken any prescription medicines during the twelve (12) 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**, until the earlier of the following:
    a. The end of a 12 consecutive month period, beginning on or after the Effective Date of coverage under this Rider, during which the **Covered Person** has]received no medical advice or treatment in connection with the **Pre-existing Condition**; or
    b. the **Covered Person** has been continuously covered for two years after the Effective Date of coverage under this Rider.
4. **Covered Injury** for which the **Covered Person** is entitled to benefits under Workers Compensation Benefits, Employer Liability Law, or other similar law.
5. Personal comfort or convenience items, such as but not limited to **Hospital** telephone charges, television rental, or guest meals.
6. Treatment by any person **Related** to the **Covered Person**.
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, elective treatment or surgery or experimental or investigative treatments or procedures.
11. A **Medical Repatriation**.
12. Expenses incurred for psychological or psychiatric counseling of any kind or any expense for treatment of mental or nervous diseases or disorders.
13. Expenses which the **Covered Person** is not legally obligated to pay.
14. Expenses for **Custodial Services** or services provided by a private duty nurse unless such expenses are incurred as a result of a **Covered Injury**.

15. 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 in the underlying bodily condition.
16. Treatment involving conditions caused by repetitive motion injuries or cumulative trauma and not a result of a **Covered Injury**.
17. Treatment of Osgood-Schlatter's Disease.

SUBROGATION

We have the right to recover from any third party all payments including future payments, which **We** have made to the **Covered Person** or on behalf of the **Insured's Spouse or Domestic Partner**, **Dependent Child(ren)**, heirs, guardians or executors or will be obligated to pay in the future to the **Insured**. If the **Covered Person** recovers from any third party, **We** will be reimbursed first from such recovery to the extent of **Our** payments to or on behalf of the **Covered Person**. The **Covered Person** agrees to assist **Us** in preserving its rights against any third party, including but not limited to, signing subrogation forms supplied by **Us**.

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

Effective Date: November 1, 2010 Attached to and forming a part of **Policy/Certificate** No. MCB 4380419