

SERFF Tracking Number: ZURC-128142480 State: Arkansas  
Filing Company: Zurich American Insurance Company State Tracking Number:  
Company Tracking Number: CW AH 34189  
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness  
Product Name: Blanket Affinity/MCM 1.2 Riders for Other Groups  
Project Name/Number: /CWAH 34189

## Filing at a Glance

Company: Zurich American Insurance Company

Product Name: Blanket Affinity/MCM 1.2 Riders SERFF Tr Num: ZURC-128142480 State: Arkansas  
for Other Groups

TOI: H04 Health - Blanket Accident/Sickness SERFF Status: Closed- State Tr Num:  
Disapproved  
Sub-TOI: H04.000 Health - Blanket Co Tr Num: CW AH 34189 State Status: Disapproved-Closed  
Accident/Sickness  
Filing Type: Form Reviewer(s): Rosalind Minor  
Author: Paula Bartell Disposition Date: 05/02/2012  
Date Submitted: 03/05/2012 Disposition Status: Disapproved  
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

## General Information

Project Name:  
Project Number: CW AH 34189  
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:  
Submission Type: New Submission  
Group Market Type: Blanket, Other

Status of Filing in Domicile: Pending  
Date Approved in Domicile:  
Domicile Status Comments: This has been filed  
for out of state approval in New York and is  
pending  
Market Type: Group  
Group Market Size: Small and Large  
Explanation for Other Group Market Type:  
Groups statutorily eligible for Blanket Coverage,  
excluding Employers and Schools/Educational  
Institutions. Eligible groups shall include, but is  
not limited to: day care centers, camps, clubs,  
community and recreation centers,  
conferences, concerts, special events,  
entertainers, volunteer organizations and  
religious and youth sports organizations  
Filing Status Changed: 05/02/2012  
State Status Changed: 05/02/2012  
Created By: Paula Bartell

Overall Rate Impact:

Deemer Date:

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Submitted By: Paula Bartell

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Healthcare.gov ID:

Filing Description:

THIS IS AN ACCIDENT ONLY PRODUCT AND DOES NOT PROVIDE COVERAGE FOR "SICKNESS".

Attached for your review are new riders for which we are seeking your approval to use with the Blanket Accident Insurance product previously filed with and authorized by your Department. As previously indicated, the Blanket Accident Insurance product and these new riders will be marketed to all statutorily eligible day care centers, camps, clubs, community and recreation centers, conferences, concerts, special events, entertainers, volunteer organizations and religious and youth sports organizations in your state consisting of two (2) or more individuals.

The Blanket Accident Insurance product and these riders may be marketed through brokers, consultants, third party administrators and sales employees.

These riders are new and are not intended to replace any other forms currently in use with the exception of U-BMC-304 which replaces a previously filed and approve "A" version.

The Blanket Accident Insurance product provides specified benefits for an accidental injury or death. Additional benefits are offered by way of riders. The forms are being filed concurrently in our domiciliary state of New York.

Coverage is offered on a contributory and non-contributory basis.

Variable data is bracketed. Amounts may vary or provisions may be modified to fit a specific Policyholder's request. Variable data will never exclude or limit provisions required by the jurisdiction in which the Policy is issued.

The forms are in final print, subject to minor variations in formatting, duplexing, shading and fonts. While every effort has been made to submit these forms without mistakes, the Company reserves the right to make corrections to any typographical errors such as misspellings or minor grammatical errors noted after filing and approval.

The Company will deem these forms approved, if upon the expiration of the initial review period, your Department has not extended the review period or otherwise has not responded to this submission.

This filing includes a certificate of readability and statement of variables.

State Narrative:

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## Company and Contact

### Filing Contact Information

Paula Bartell, Project Manager paula.bartell@zurichna.com  
 1400 American Lane 847-605-6177 [Phone]  
 Schaumburg, IL 60196-1056 847-605-7768 [FAX]

### Filing Company Information

Zurich American Insurance Company CoCode: 16535 State of Domicile: New York  
 1400 American Lane Group Code: 212 Company Type:  
 Schaumburg, IL 60102 Group Name: State ID Number:  
 (847) 605-6000 ext. [Phone] FEIN Number: 36-4233459

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$1,050.00  
 Retaliatory? No  
 Fee Explanation: 21 forms X \$50  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Zurich American Insurance Company	\$1,050.00	03/05/2012	56862225

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Disapproved	Rosalind Minor	05/02/2012	05/02/2012

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending	Rosalind Minor	03/06/2012	03/06/2012			
Industry Response						

SERFF Tracking Number: ZURC-128142480 State: Arkansas  
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Project Name/Number: /CWAH 34189

## Disposition

Disposition Date: 05/02/2012

Implementation Date:

Status: Disapproved

HHS Status: HHS Denied

State Review: Reviewed-No Actuary

Comment:

This submission is being disapproved since we did not receive a response to our Objection Letter of 3/6/12.

Thank you for your understanding in this matter.

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Disapproved	Yes
Supporting Document	Application	Disapproved	Yes
Supporting Document	PPACA Uniform Compliance Summary	Disapproved	Yes
Supporting Document	Statement of Variables for Arkansas	Disapproved	Yes
Supporting Document	Red-Lined Form	Disapproved	Yes
Form	Administrative Change Endorsement	Disapproved	Yes
Form	Eligibility of Dependents Benefit	Disapproved	Yes
Form	Additional Accidental Dismemberment [and Covered Loss of Use] [and Plegia] for Dependent Children Benefit	Disapproved	Yes
Form	Critical Burn Benefit	Disapproved	Yes
Form	Permanent Temporary Total Disability Benefit	Disapproved	Yes
Form	After School Care Benefit	Disapproved	Yes
Form	Inflation Benefit	Disapproved	Yes
Form	HIV Occupational Accident Benefit	Disapproved	Yes
Form	Continuation of Insurance Benefit	Disapproved	Yes
Form	Day Care Benefit	Disapproved	Yes
Form	Hearing Aid or Prosthetic Appliance Benefit	Disapproved	Yes
Form	Emergency [Transportation] [and] [Treatment] [and] Hospital Cash Benefit	Disapproved	Yes
Form	Traumatic Brain Injury Benefit	Disapproved	Yes
Form	Home Alteration and Vehicle Modification Benefit	Disapproved	Yes
Form	Natural Disaster Benefit	Disapproved	Yes
Form	[Occupational] [or] [Voluntary Activity] Hepatitis Benefit	Disapproved	Yes
Form	Recuperation Benefit	Disapproved	Yes
Form	Student [Tuition] [and] [Expense] Reimbursement Benefit	Disapproved	Yes
Form	Accelerated Payment Benefit	Disapproved	Yes
Form	Accident Medical Expense Indemnity Benefit	Disapproved	Yes
Form	Complications of Pregnancy Benefit	Disapproved	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 03/06/2012

Submitted Date 03/06/2012

Respond By Date

Dear Paula Bartell,

This will acknowledge receipt of the captioned filing.

Objection 1

- Eligibility of Dependents Benefit , U-BMC-308-A AR (09/11) (Form)

Comment:

The rider states that a child of an insured born while this policy is in force is covered from the moment of birth for a period of sixty (60) days. ACA

23-79-129 states that the child is covered for 90 days.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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## Form Schedule

### Lead Form Number: U-BMC-308-A

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Disapprove d 05/02/2012	U-BMC- 304-B CW (09/11)	Policy/Cont ractal	Administrative Change Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Revised	Replaced Form #: U- BMC-304-A CW Previous Filing #: 47575	48.000	U-BMC-304-B CW - Admin Change Endorsement. pdf
Disapprove d 05/02/2012	U-BMC- 308-A AR (09/11)	Policy/Cont ractal	Eligibility of Dependents Benefit Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		51.000	U-BMC-308-A AR Eligibility of Dependents.p df
Disapprove d 05/02/2012	U-BMC- 309-A CW (09/11)	Policy/Cont ractal	Additional Accidental Dismemberment [and Covered Loss of Certificate: Use] [and Plegia] for Amendmen t, Insert Page, Endorseme nt or Rider	Initial		48.000	U-BMC-309-A CW AD&Covered Loss Use.pdf
Disapprove d 05/02/2012	U-BMC- 318-A CW (09/11)	Policy/Cont ractal	Critical Burn Benefit Certificate:	Initial		55.000	U-BMC-318-A CW Critical Burn.pdf

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<i>Company Tracking Number:</i>	CW AH 34189		
<i>TOI:</i>	H04 Health - Blanket Accident/Sickness	<i>Sub-TOI:</i>	H04.000 Health - Blanket Accident/Sickness
<i>Product Name:</i>	Blanket Affinity/MCM 1.2 Riders for Other Groups		
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	Amendmen t, Insert Page, Endorseme nt or Rider		
Disapprove U-BMC- d 320-A AR 05/02/2012 (09/11)	Policy/Cont Permanent ract/Fratern Temporary Total al Disability Benefit Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	38.000
			U-BMC-320-A AR Permanent Temporary Total Disability.pdf
Disapprove U-BMC- d 323-A AR 05/02/2012 (09/11)	Policy/Cont After School Care ract/Fratern Benefit al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	49.000
			U-BMC-323-A AR After School Care Benefit.pdf
Disapprove U-BMC- d 324-A CW 05/02/2012 (09/11)	Policy/Cont Inflation Benefit ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	40.000
			U-BMC-324-A CW Inflation Rider.pdf
Disapprove U-BMC- d 331-A CW 05/02/2012 (09/11)	Policy/Cont HIV Occupational ract/Fratern Accident Benefit al Certificate: Amendmen t, Insert	Initial	48.000
			U-BMC-331-A CW HIV Occ Benefit.pdf

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<i>TOI:</i>	H04 Health - Blanket Accident/Sickness	<i>Sub-TOI:</i>	H04.000 Health - Blanket Accident/Sickness	
<i>Product Name:</i>	Blanket Affinity/MCM 1.2 Riders for Other Groups			
<i>Project Name/Number:</i>	/CWAH 34189			
	Page,			
	Endorseme			
	nt or Rider			
Disapprove U-BMC- d 347-A CW 05/02/2012 (09/11)	Policy/Cont Continuation of ract/Fratern Insurance Benefit al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	53.000	U-BMC-347-A CW Continuation of Insurance.pdf
Disapprove U-BMC- d 348-A AR 05/02/2012 (09/11)	Policy/Cont Day Care Benefit ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	53.000	U-BMC-348-A AR Day Care Benefit.pdf
Disapprove U-BMC- d 349-A CW 05/02/2012 (09/11)	Policy/Cont Hearing Aid or ract/Fratern Prosthetic Appliance al Benefit Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	51.000	U-BMC-349-A CW Hearing Aid.pdf
Disapprove U-BMC- d 353-A CW 05/02/2012 (09/11)	Policy/Cont Emergency ract/Fratern [Transportation] [and] al [Treatment] [and] Certificate: Hospital Cash Amendmen Benefit t, Insert Page, Endorseme	Initial	37.000	U-BMC-353-A CW Emergency Hospital & Ambulance Cash.pdf

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<i>Company Tracking Number:</i>	CW AH 34189			
<i>TOI:</i>	H04 Health - Blanket Accident/Sickness	<i>Sub-TOI:</i>	H04.000 Health - Blanket Accident/Sickness	
<i>Product Name:</i>	Blanket Affinity/MCM 1.2 Riders for Other Groups			
<i>Project Name/Number:</i>	/CWAH 34189			
	nt or Rider			
Disapprove U-BMC- d 361-A AR 05/02/2012 (09/11)	Policy/Cont Traumatic Brain ract/Fratern Injury Benefit al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	48.000	U-BMC-361-A AR Traumatic Brain Injury.pdf
Disapprove U-BMC- d 371-A CW 05/02/2012 (09/11)	Policy/Cont Home Alteration and ract/Fratern Vehicle Modification al Benefit Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	42.000	U-BMC-371-A CW Home Alteration.pdf
Disapprove U-BMC- d 372-A CW 05/02/2012 (09/11)	Policy/Cont Natural Disaster ract/Fratern Benefit al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	58.000	U-BMC-372-A CW Natural Disaster.pdf
Disapprove U-BMC- d 373-A CW 05/02/2012 (09/11)	Policy/Cont [Occupational] [or] ract/Fratern [Voluntary Activity] al Hepatitis Benefit Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	36.000	U-BMC-373-A CW Occ-Vol Activity Hepatitis Benefit.pdf
Disapprove U-BMC-	Policy/Cont Recuperation Benefit	Initial	57.000	U-BMC-374-A

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Product Name:	Blanket Affinity/MCM 1.2 Riders for Other Groups		
Project Name/Number:	/CWAH 34189		
d	374-A CW	ract/Fratern	CW
05/02/2012 (09/11)		al	Recuperation
		Certificate:	Benefit.pdf
		Amendmen	
		t, Insert	
		Page,	
		Endorseme	
		nt or Rider	
Disapprove U-BMC-	Policy/Cont Student [Tuition]	Initial	38.000
d	375-A CW	ract/Fratern [and] [Expense]	U-BMC-375-A
05/02/2012 (09/11)	al	Reimbursement	CW Tuition
		Certificate: Benefit	Reimburseme
		Amendmen	nt.pdf
		t, Insert	
		Page,	
		Endorseme	
		nt or Rider	
Disapprove U-BMC-	Policy/Cont Accelerated Payment	Initial	39.000
d	376-A CW	ract/Fratern Benefit	U-BMC-376-A
05/02/2012 (09/11)	al		CW
		Certificate:	Acclerated
		Amendmen	Payment.pdf
		t, Insert	
		Page,	
		Endorseme	
		nt or Rider	
Disapprove U-BMC-	Policy/Cont Accident Medical	Initial	49.000
d	377-A CW	ract/Fratern Expense Indemnity	U-BMC-377-A
05/02/2012 (09/11)	al	Benefit	CW AME
		Certificate:	Indemnity.pdf
		Amendmen	
		t, Insert	
		Page,	
		Endorseme	
		nt or Rider	
Disapprove U-BMC-	Policy/Cont Complications of	Initial	32.000
d	378-A AR	ract/Fratern Pregnancy Benefit	U-BMC-378-A
05/02/2012 (09/11)	al		AR
			Complication

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nt or Rider

# Administrative Change Endorsement



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

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

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

[This endorsement will be used to make the following types of administrative changes to the **Policy**:

1. **Policyholder's** Name or Address;
2. Addition or deletion of subsidiaries or affiliates of the **Policyholder**;
3. Changes to the class(es) of eligible persons;
4. Addition or deletion of Benefit Riders;
5. Increase or decrease in Coverage Amount(s); or
6. Renewal of the **Policy**.]

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

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_

# Eligibility of Dependents



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

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

It is hereby understood and agreed that the following language amends and is incorporated into the **Policy**:

Section II Eligibility And Effective Dates Of Insurance is amended to include the following:

An **Insured** may elect to cover their eligible **Dependents**. An eligible **Dependent** includes the **Insured's Spouse[/Domestic Partner]** and the **Insured's Dependent Child(ren)**, [and] [his or her **Spouse's Dependent Child(ren)**] [, and his or her **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 this **Policy**. If the **Insured** and his or her **Spouse[/Domestic Partner]**, or former **Spouse[/Domestic Partner]**, are both **Insureds** under this **Policy**, only one may select a **Plan** covering their mutual **Dependents**.

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

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

[A child of an **Insured** born while this **Policy** is in force is covered from the moment of birth for a period of sixty(60) days. An adopted newborn child of an **Insured** is covered from the moment of birth for a period of sixty (60) days. After this time, the child will remain covered only if the **Insured** has provided written notice of birth or filling of a petition for adoption to the **Policyholder** and pays the required premium due, if any.]

[A newly adopted child of an **Insured** is covered from the moment of adoption or the date of filing of a petition for adoption, for a period of sixty (60) days. After this time, the child will remain covered only if the **Insured** has provided written notice to the **Policyholder** of the adoption or the filing of a petition for adoption, and pays the required premium due, if any.]

[All insurance for a **Dependent** will terminate on the earliest of the following:

1. On the date that the **Policy** is terminated;
2. On any premium due date if the premium is not received prior to the end of the Grace Period;
3. On the date the **Dependent** reaches age [seventy (70)]; or
4. On the first premium due date following the date the person no longer qualifies as a **Dependent**.]

Termination of the **Policy** or of any **Insured's** coverage will be without prejudice to any claim which commenced prior to the effective date of termination.

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

<u>Plan Selected</u>	<u>% Spouse[/Domestic Partner]</u>	<u>% Child(ren)</u>
<b>Spouse[/Domestic Partner]</b> only:	[50%]	0
<b>Dependent Child(ren)</b> only:	0	[15%]
<b>Spouse[/Domestic Partner]</b> and <b>Dependent Child(ren)</b> ;	[40%]	[10%]

For purposes of this rider, the following additional definitions apply:

**[Dependent]** means the **Insured's Spouse [Domestic Partner]** and **Dependent Child(ren)**, as defined in this section. [A **Dependent** will only be a covered **Dependent** if a **Plan** covering **Dependents** is selected and all other conditions of coverage are satisfied.]

**[Dependent Child(ren)]** means the **Insured's** unmarried child(ren) and those of the **Insured's Spouse [Domestic Partner]** who rely on the **Insured** for support, and are either: 1) less than [19 (nineteen)] years of age; 2) less than [25 (twenty-five)] years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental or physical handicap.]

**Related** means [the **Insured's Spouse/Domestic Partner**] or other adult living with the **Insured**], sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_



**ZURICH**<sup>®</sup>

# **Additional Accidental [Dismemberment] [and Covered Loss of Use] [and Plegia] for Dependent Children Benefit**

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

## **THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

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

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

If an **Insured** selects a **Plan** covering his or her eligible **Dependent Child(ren)**, and a covered **Dependent Child** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental [Dismemberment] [and] [Covered Loss of Use] [and Plegia] Benefit, **We** will pay the **Insured** an additional benefit which will be equal to the Coverage Amount provided by the Accidental [Dismemberment] [and] [Covered Loss of Use] [and Plegia] Benefit.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_

# Critical Burn Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

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

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

If an **Insured** suffers a **Covered Injury** that is a **Critical Burn** resulting in a **Covered Loss** as a result of a **Covered Accident**, **We** will pay a Coverage Amount as shown in the Schedule, provided:

1. the **Insured** received [second degree or higher] burns over at least [twenty-five (25%)] of his or her body; and[.]
2. [within [three hundred sixty-five (365)] days of the **Covered Accident**, the **Insured** has undergone reconstructive surgery to treat the burned areas of the body.]

For purposes of this rider only, **Critical Burn** means cosmetic disfigurement of the surface of a body area due to a **Covered Injury** [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.]

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_

# [Permanent] [Temporary] Total Disability Benefit



ZURICH AMERICAN INSURANCE COMPANY

1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

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

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

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss** that renders the **Insured** [Permanently] [Temporarily] **Totally Disabled**, **We** will pay a [Permanent][Temporary] Total Disability Benefit provided that the **Insured** becomes [permanently][temporarily] **Totally Disabled** within [three hundred sixty-five (365)] days of the **Covered Injury** and the [permanent][temporary] **Total Disability** continues for [twelve (12)] consecutive months.

The [monthly] [lump sum] amount payable under this benefit will be equal to the Coverage Amount shown on the Schedule. [The payments under this benefit will cease at the earliest of the following times:

1. **We** make [sixty (60)] payments under this benefit;
2. the **Insured** is no longer permanently and **Totally Disabled**; or
3. the **Insured** dies.

Payments will begin on the thirty-first (31<sup>st</sup>) consecutive day of **Total Disability** and will continue for as long as the **Insured** is [permanently][temporarily] **Totally Disabled**, but will not exceed the **Benefit Period** of [sixty (60)] months.] As a condition of coverage, **We** must receive proof of continuing **Total Disability** on a regular basis.]

Successive periods of **Total Disability** arising out of the same **Covered Injury** will be considered one **Total Disability** if they are separated by a period of less than [six (6)] months.

For purposes of this rider only, the following additional definitions apply:

[**Benefit Period** means the time period that benefits are payable under this benefit subject to any other restrictions or limitations in the **Policy**.]

**Continuous Care** means monthly monitoring and/or evaluation of the disabling condition by a **Physician**.

**Total Disability and Totally Disabled** means disability that:

1. prevents an **Insured** from performing the material and substantial duties of any occupation for which the **Insured** is qualified by reason of education, training, or experience [or if for an **Insured** who is not employed means that the person is unable to engage any of the usual activities of a person of like age and sex whose health is comparable to that of the **Insured**] immediately prior to the **Covered Accident**; and
2. requires the **Continuous Care** and treatment of a **Physician**.

If the **Insured** does not adhere to the treatment plan the **Physician** prescribes relating to his or her disabling condition, the **Insured** shall not qualify for the [Permanent][Temporary] Total Disability Benefit. The **Insured** shall not qualify for **Total Disability** if the **Insured** engages in any activity, such as employment, that results in earned income.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_

# After School Care Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

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

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

If an **Insured** [selects a **Plan** covering his or her [**Dependents**][**Dependent Child(ren)**] and the **Insured** or his or her **Spouse** [**Domestic Partner**] suffers a **Covered Injury** resulting in a **Covered Loss** which is payable under the [Accidental Death [and Accidental Dismemberment]] Benefit, **We** will reimburse the charges actually incurred by the **Insured** for the after school care for each **Dependent Child**, who is [ten (10)] years old or less, up to the Coverage Amount shown on the Schedule.

The after school care provider may not be **Related** to the **Insured** and proof must be provided with the Proof of Covered Loss to establish eligibility for this benefit.

[If the **Insured** and his or her **Spouse** [**Domestic Partner**] both die as a result of the same **Covered Injury**, and **We** pay a[n] [Accidental Death] Coverage Amount on the **Insured** and his or her **Spouse** [**Domestic Partner**], only the **Insured's** Coverage Amount will be used to calculate the amount applicable under this benefit.]

This benefit will be paid each year for [four (4)] consecutive years if the **Dependent Child(ren)** [is][are] under age [ten (10)] at the time of each payment.]

For purposes of this rider only, the following additional definition applies:

**Related** means [the **Insured's Spouse** [**Domestic Partner**] or other adult living with the **Insured**], sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_

# Inflation Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

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

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

If an **Insured** sustains a **Covered Injury** that results in a **Covered Loss** payable under the [Accidental Death [and Accidental Dismemberment]] Benefit, the Inflation Benefit will provide an inflation adjustment to the Coverage Amount.

The Inflation Benefit is the **Insured's** Coverage Amount at the time of claim, multiplied by the product of:

1. the Inflation Benefit Percentage as shown on the Schedule; and
2. one (1) credited year for every 2 years of continuous coverage under the **Policy** prior to the **Covered Loss**; to a maximum of [ten (10)] multiplied by the injured **Insured's** original Coverage Amount [(Coverage Amount) x (Benefit Percentage x Years of Credited Coverage) = Inflation Benefit Coverage Amount.]

[If an **Insured** increases the Coverage Amount, **We** will apply the Inflation Benefit separately to each additional increase under the **Policy**. Likewise, if an **Insured** decreases the Coverage Amount, **We** will correspondingly reduce any Inflation Benefit that was previously increased.]

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_

# HIV Occupational Accident Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

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

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

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss** while performing his or her job related duties, which causes the **Insured** to acquire and test positive within [three hundred sixty-five (365)] days of such **Covered Accident** for Human Immunodeficiency Virus (HIV) and/or AIDS and related complex (ARC), **We** will pay an HIV Occupational Accident Benefit. Such HIV Occupational Accident Benefit will be equal to the Coverage Amount shown on the Schedule. The HIV Occupational Accident Benefit will be paid in [twenty-four (24)] equal monthly installments.

In order to receive the HIV Occupational Accident Benefit, the **Insured** must:

1. submit a workers' compensation injury report to his or her employer within seventy-two (72) hours of the **Covered Accident**. If the **Insured's** employer does not maintain workers' compensation insurance, the **Insured** must complete a Proof of Covered Loss form that **We** will provide. The completed Proof of Covered Loss form must be approved by the **Insured's** employer within seventy-two (72) hours of the **Covered Accident** and must be submitted to **Us** within five (5) days of the **Covered Accident**; and
2. submit to a blood test for HIV and/or AIDS and/or related complex (ARC) within seventy-two (72) hours of the **Covered Accident**, which is administered by a **Physician**. The blood test results must be sent directly to **Us**.

If the initial test is negative and the **Insured** subsequently tests positive for HIV, AIDS or ARC within [three hundred sixty-five (365)] days of the **Covered Accident**, **We** will begin monthly payments on the first day of the month following receipt of the report indicating positive test results.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_



# Continuation of Insurance Benefit

ZURICH AMERICAN INSURANCE COMPANY

1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

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

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

If the **Insured** [selects a **Plan** covering his or her **Spouse[/Domestic Partner]]** [and **Dependent Child(ren)** and the **Insured**] suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Death Benefit, provided there are no premium payments in arrears, all benefits under this **Policy** which were in force on the date of the loss will continue with respect to the **Insured's** eligible **Dependents** for [three hundred sixty-five (365)] days after the date of loss with no additional premium payments.

For purposes of this rider only, insurance for eligible **Dependents** terminates on the earliest of:

1. [three hundred sixty-five (365)] days after the date of **Covered Loss**;
2. the first premium due date after the **Dependent** no longer qualifies as an **Insured**;
3. [for the covered **Spouse/Domestic Partner**], the date the covered **Spouse/Domestic Partner** reaches age [seventy (70)].]

For purposes of this rider only, the following additional definitions apply:

**Dependent(s)** means an **Insured's Spouse [/Domestic Partner]** and **Dependent Child(ren)**, as defined in this section. [The **Dependent** will only be a covered **Dependent** if a **Plan** covering **Dependents** is selected.]

**Dependent Child(ren)**, means the unmarried child(ren) of the **Insured**, [and] [the unmarried child(ren) of his or her **Spouse[/Domestic Partner]]** [, and the unmarried child(ren) as defined in the **Policyholder's** [medical] plan as on file and approved by **Us**] who rely on the **Insured** for [more than fifty (50%) of] their support, and are either: 1) less than [nineteen(19)] years of age; 2) less than [twenty-five (25)] years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental or physical handicap. [The **Dependent Child(ren)** will only be covered **Dependent Child(ren)** if a **Plan** covering **Dependent Child(ren)** is selected.]

**Related** means [the **Insured's Spouse[/Domestic Partner]** or other adult living with the **Insured**], sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.

**Spouse** means the **Insured's** legally married **Spouse** [under age seventy (70)]. [A **Spouse** will only be a covered **Spouse** if a **Plan** covering the **Insured's Spouse** is selected.]

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_

# Day Care Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

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

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

If an **Insured** [selects a **Plan** covering his or her **Dependents** and the **Insured** or his or her covered **Spouse** [/**Domestic Partner**]] suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Death Benefit, **We** will pay an additional benefit for day care expenses to the individual who incurs the expense on behalf of each covered **Dependent Child** if:

1. on the date of the **Covered Accident**, the covered **Dependent Child** was enrolled in an **Accredited Child Care Facility**, or enrolls in such facility within [ninety (90)] days from the date of loss; and
2. the **Dependent Child** is under age [thirteen (13)].

The Day Care Benefit will be equal to the lesser of:

1. the actual cost of the child care;
2. [three (3%)] of the Coverage Amount of the **Insured** who suffered the **Covered Loss**; or
3. [\$3,000].

If both an **Insured** and his or her covered **Spouse**[/**Domestic Partner**] suffer a simultaneous **Covered Loss** which is payable under the Accidental Death Benefit, the Day Care Benefit will be based on the **Insured's** Coverage Amount.

The Day Care Benefit will be paid annually for [four (4)] consecutive years if:

1. the covered **Dependent Child** is under age [thirteen (13)] at the time of each annual payment; and
2. proof is received by **Us** that verifies that the covered **Dependent Child** remains enrolled in an **Accredited Child Care Facility**.

For purposes of this rider only, the following additional definitions apply:

An **Accredited Child Care Facility** means:

1. a child care facility that operates pursuant to state and local laws;
2. is licensed by the state for such child care facilities; and
3. has been provided with a Tax Identification Number by the Internal Revenue Service.

An **Accredited Child Care Facility** does not include a **Hospital**, the **Dependent Child's** home, a nursing or convalescent home, a facility for the treatment of mental disorders, an orphanage, or a treatment center for drug and alcohol abuse.

**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 twenty-four (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**.

The maximum amount payable under this benefit is [\$4,000].

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_

# Hearing Aid or Prosthetic Appliance Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

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

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

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit, **We** will pay an additional benefit provided:

1. the **Insured** is required to use a Hearing Aid or **Prosthetic Appliance**;
2. the **Covered Injury** that caused the payment of the Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit is the same **Covered Injury** that requires the **Insured** to use the Hearing Aid or **Prosthetic Appliance**; and
3. the Hearing Aid or **Prosthetic Appliance** was required within [three hundred sixty-five (365)] days of the **Covered Injury**.

The amount **We** will pay will be equal to the one time cost of the Hearing Aid or **Prosthetic Appliance** actually paid by the **Insured**.

This benefit will not be paid unless:

1. the Hearing Aid or **Prosthetic Appliance** was prescribed by a **Physician** who is not **Related** to the **Insured**; and
2. proof of payment is provided to **Us**.

The maximum amount payable under all provisions of this benefit combined will be the lesser of [ten (10%)] of the Coverage Amount of the **Insured** that sustained the **Covered Injury** or [\$10,000].

For purposes of this rider only, the following additional definitions apply:

**Prosthetic Appliance** means a replacement or artificial substitution for a missing **Limb** or eye. This does not include a dental prosthetic device such as dentures or crowns.

**Related** means [the **Insured's Spouse**]/**Domestic Partner**] or other adult living with the **Insured**], sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_

# Emergency [Transportation] [and] [Treatment] [and] Hospital Cash Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

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

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

### [EMERGENCY TRANSPORTATION BENEFIT

If an **Insured** suffers a **Covered Injury** that requires **Emergency Treatment** within [12, 24, 48] hours of the date of the **Covered Accident** that caused the **Covered Injury** and it is determined that it is **Medically Necessary** that the **Insured** be transported to a **Hospital** or a **Satellite Emergency Center** by **Ambulance**, **We** will pay 100% of the Emergency Transportation Coverage Amount shown in the Schedule. Only one Emergency Transportation Benefit is payable for any one **Covered Accident** per **Insured**. [The maximum number of Emergency Transportation Benefits payable per calendar year per **Insured** regardless of the number of **Accidents** incurred, is shown in the Schedule.]]

### [EMERGENCY TREATMENT BENEFIT

If an **Insured** suffers a **Covered Injury** that, within [24,48,72] hours of the date of the **Covered Accident** that caused the **Covered Injury**, requires him or her to receive **Medically Necessary Emergency Treatment** in a **Hospital** emergency room or a **Satellite Emergency Center**, **We** will pay 100% [of the applicable] Emergency Treatment Benefit Coverage Amount shown in the Schedule. Only one Emergency Treatment Benefit [, the largest,] is payable for any one **Covered Accident** per **Insured**. [The maximum number of Emergency Treatment Benefits payable per calendar year per **Insured** regardless of the number of **Covered Accidents** incurred, is shown in the Benefit Schedule.]]

[If an **Insured** requires both Emergency Transportation and **Emergency Treatment** due to the same **Covered Accident**, only one Coverage Amount, the highest, will be paid.] [A maximum of [two (2)] Emergency Transportation Benefits or **Emergency Treatment** Benefits are payable per **Insured** per calendar year regardless of the number of **Covered Accidents** incurred in that same calendar year.]

### EMERGENCY HOSPITAL CASH

If the **Insured** is **Hospital Confined** due to **Covered Injury**, **We** will pay a daily allowance according to the actual days in **Hospital** up to the maximum benefit of [thirty (30)] days. [**We** will not pay any claim for the first three (3) calendar days of each emergency **Hospital Confinement** within the United States.]

For purposes of this rider only, the following additional definitions apply:

**Ambulance** means any publicly or privately owned surface, water or air vehicle, including a helicopter, that is specifically designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded.

**Ambulance** does not include a surface, water or air vehicle that is owned and operated to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport.]

**Emergency Treatment** means treatment for:

1. a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the person (or with respect to a pregnant woman, the health of her unborn child) in serious jeopardy;

2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

**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 Confinement (Hospital Confined)** means admission to a **Hospital** as an inpatient for at least [twenty-four (24)] consecutive hours by a **Physician** for a **Covered Injury**. A **Hospital** stay that does not result in charges to the **Insured** is not a **Hospital Confinement** under this rider unless there is no charge because the **Hospital** is a United States government facility.

**Medically Necessary** means an [**Emergency Treatment**] [or] [Emergency Transportation] is:

1. essential for the diagnosis, treatment and care of the **Covered Injury**;
2. meets generally accepted standards of medical practice; [or]
3. is ordered by a **Physician** and performed under the **Physician's** care, supervision or order; or
4. [with regard to Emergency Transportation, is subsequently authorized by a **Physician** as appropriate due to the nature of the **Covered Injury**].

**Satellite Emergency Center** means a licensed facility providing outpatient care under the direction of a **Physician** on a twenty-four (24) hour basis. Available services must include:

1. diagnostic care, including laboratory services and diagnostic x-rays; and
2. treatment or medical care, including availability of the means for stabilization of emergency medical conditions.

A **Satellite Emergency Center** does not include a **Hospital** or an office maintained by a **Physician** for the practice of medicine or dentistry.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_

# Traumatic Brain Injury Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

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

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

If an **Insured** suffers a **Covered Injury** resulting in a **Traumatic Brain Injury** within [ninety (90)] days of the date of **Covered Accident** which:

1. requires that an **Insured** be **Hospitalized** for at least [seven (7)] days during the first [ninety (90)] days following the **Covered Accident**; and
2. continues for [nine (9)] consecutive months,

**We** will pay a **Traumatic Brain Injury** Benefit.

This benefit will be paid after **We** receive Proof of Covered Loss in accordance with Proof of Covered Loss section of the **Policy**.

The **Traumatic Brain Injury** Benefit is equal to the Coverage Amount of the **Insured** that sustained the **Covered Injury**.

[**We** will not pay this benefit if a benefit is payable to an **Insured** for Loss of Life under the Accidental Death [and Accidental Dismemberment] Benefit].

For purposes of this rider only, the following additional definitions apply:

**Hospital** or **Hospitalized** means admission to 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 twenty-four (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**.

**Traumatic Brain Injury** means physical damage to the brain which is certified by a **Physician** to be:

1. permanent, complete and irreversible; and

- prevents the injured person from performing all the substantial and material functions and activities of a person of like age and gender in good health.

The specific amounts for this Benefit are shown in the Schedule.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_

# Home Alteration and Vehicle Modification Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

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

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

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit, **We** will pay an additional benefit for home alterations and vehicle modifications, provided:

1. the **Insured** is required to use a wheelchair to be ambulatory on a permanent basis; and
2. the **Covered Injury** that caused the payment of the Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit is the same **Covered Injury** that requires the **Insured** to use a wheelchair.

The amount **We** will pay will be equal to the one time cost of:

1. home alterations to the **Insured's** primary residence to make it wheelchair accessible and habitable; and
2. vehicle modifications necessary to the **Insured's** primary use motor vehicle to make the vehicle accessible or driver-side modification for wheelchair use.

For purposes of this rider only, benefits will not be payable unless:

1. the home alterations and vehicle modifications are made by a person or persons experienced in such home alterations and vehicle modifications, and are recommended by a recognized organization providing support and assistance to wheelchair users; and
2. proof of payment for the home alterations and vehicle modifications is provided to **Us**.

The maximum amount payable under all provisions of this benefit combined will be the lesser of [ten (10%)] of the Coverage Amount of the **Insured** that sustained the **Covered Injury** or [\$10,000].

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_



## Natural Disaster Benefit

**ZURICH AMERICAN INSURANCE COMPANY**

1400 American Lane  
Schaumburg, Illinois 60196

### **THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

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

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

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Death [or Accidental Dismemberment] [and Covered Loss of Use] [and Plegia] Benefit, **We** will pay a benefit equal to the lesser of [ten (10%)] of the **Insured's** Coverage Amount or [\$10,000], provided the **Insured** suffers the **Covered Injury** as a direct result of a **Natural Disaster**.

For purposes of this rider only, **Natural Disaster** means a weather event such as a storm (wind, rain, snow, sleet, hail, lightning, dust or sand), earthquake, flood, volcanic eruption, wildfire or other similar event, that arises from natural causes without direct human involvement and results in severe and widespread damage.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_

# [Occupational] [or] [Voluntary Activity] Hepatitis Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

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

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

If an **Insured** tests positive for **Hepatitis** within [three hundred sixty-five (365) days] of the date of an **[Occupational Incident] [or] [Volunteer Activity]**, **We** will pay the Coverage Amount to the **Insured** as shown in the Schedule. The benefit is payable if, within seventy-two (72) hours of the **[Occupational Incident] [or] [Volunteer Activities]**, the **Insured**:

1. reports the **[Occupational Incident] [or] [Volunteer Activity]** to **Us** in writing; and
2. undergoes a Food and Drug Administration (FDA) approved preliminary screening test for **Hepatitis** which indicates negativity with respect to the presence of any antibodies or antigens to such disease.

**We** must receive written notification of the test results from the laboratory which performed the test as soon as reasonably possible.

The benefit is payable monthly, starting on the last day of the month which immediately follows the month the **Insured** tests positive for **Hepatitis**, for [one hundred twenty-seven (127)] consecutive months or until:

1. the date the **Insured** dies; or
2. the date the **Insured** recovers from **Hepatitis**, whichever occurs first.

If the **Insured** tests positive for **Hepatitis** as a result of the same **[Occupational Incident] [or] [Volunteer Activity]**, only one Coverage Amount, the largest, will be paid. **We** will not pay for any expenses incurred for testing.

For purposes of this rider only, the following additional definitions apply:

**Hepatitis** means inflammation of the liver caused by a virus or a toxin. **Hepatitis** includes Hepatitis [A], B, C, D and E.

**[Occupational Incident(s)]**, means a **Covered Accident** resulting in exposure to **Hepatitis** which occurs while the **Insured** is performing occupational services. The exposure must be either:

1. cutaneous through abraded skin;
2. percutaneous; or
3. mucocutaneous.]

**[Volunteer Activity (Volunteer Activities)]** means a **Covered Accident** resulting in exposure to **Hepatitis** which occurs while the **Insured** is performing services as a volunteer. The exposure must be either:

1. cutaneous through abraded skin;
2. percutaneous; or
3. mucocutaneous.]

This rider only provides benefits for **[Occupational Incidents] [or] [Volunteer Activity]** as defined above.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_



## Recuperation Benefit

**ZURICH AMERICAN INSURANCE COMPANY**

1400 American Lane  
Schaumburg, Illinois 60196

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

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

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

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss** and the **Insured** is eligible to receive benefits payable under the [In-Hospital Indemnity Benefit] of the **Policy**, **We** will pay an additional Recuperation Benefit.

The Recuperation Benefit is equal to the Coverage Amount shown on the Schedule and will be paid for the same [period of time as the][number of days as was actually paid for the] [In-Hospital Indemnity Benefit].

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_



ZURICH®

# Student [Tuition] [and] [Expense] Reimbursement Benefit

Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

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

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

### [Student Loan Reimbursement

If [a **Covered Person**] [an **Insured**] that is a **Tuition Payor** and suffers a **Covered Loss** that is payable under the [Accidental Death [and Accidental Dismemberment]][Critical Illness] Benefit, **We** will pay the [**Covered Person's**][**Insured's**] outstanding loan balance incurred **Student Tuition** as of date of the **Covered Loss** and owed to a financial institution or federal government for **Academic Studies**. The most **We** will pay is up to the Coverage Amount shown on the Schedule.]

### [Tuition Reimbursement

If [a **Covered Person**][an **Insured**] is enrolled in **Academic Studies** and suffers a **Covered Loss** that is payable under the [Accidental Death [and Accidental Dismemberment]][Critical Illness] Benefit and which prevents the injured [**Covered Person**][**Insured**] from continuing to participate in **Academic Studies**, **We** will pay **Tuition Expense(s)** up to the Coverage Amount shown on the Schedule.]

### [Student Tuition and Tuition Expenses

If [a **Covered Person**][an **Insured**] that is a **Tuition Payor** and suffers a **Covered Loss** that is payable under the [Accidental Death [and Accidental Dismemberment]][Critical Illness] Benefit and there is an obligation to pay **Student Tuition** [to the **Policyholder**] on behalf of the **Covered Person**, **We** will pay an annual benefit up to the maximum number of payments as shown on the Schedule. The Coverage Amount will increase annually by the lesser of the actual **Student Tuition** and **Tuition Expense**, or [(ten (10%)).]

### [Student Expenses

If [a **Covered Person**][an **Insured**] is a **Tuition Payor** and suffer(s) a **Covered Loss** that is payable under the [Accidental Death [and Accidental Dismemberment]][Critical Illness] Benefit and prevents the **Tuition Payor** from continuing to pay the **Student Expenses** incurred by the **Covered Person** for **Academic Studies**, **We** will pay an annual benefit up to the maximum number of payments as shown on the Schedule. The Coverage Amount will increase annually by the lesser of the actual **Student Expenses** or [ten (10%)].]

For purposes of this rider only, the following additional conditions apply:

**Eligibility of a Covered Person.** At the time of the **Covered Loss**, the **Covered Person** must be enrolled as a full-time student or have already been accepted by an accredited university, college, charter school, private school, magnet school, parochial school, or other such similar school where a **Tuition Expense** is incurred for **Academic Studies**.

**Payment Of Claims.** Unless otherwise requested by the **Insured**, the [Accidental Death [and Accidental Dismemberment]][Critical Illness] Benefit will be paid directly to the [**Covered Person**] [or beneficiary] [or **Policyholder**] up to the total amount of actual [**Tuition Expense**] [and] [**Student Expenses**] due from the **Tuition Payor**. Any payment made in good faith will release **Us** from any liability to the extent of the payment.

For purposes of this rider only, the following additional definitions apply:

**Academic Studies** means the full-time attendance at an educational institution or school for the purpose of advancing education and for which the **Tuition Payor** incurred **Student Tuition** [and room and board (if supplied by the university, college or trade school)] to attend.

[**Covered Person** means any person who has insurance under the terms of this **Policy**. It includes the **Insured** [,and his or her **Spouse[/Domestic Partner]** and/or **Dependent Child(ren)** if a **Plan** covering the **Spouse [/Domestic Partner]** and/or **Dependent Child(ren)** is selected. **Covered Person** also includes the **Spouse[/Domestic Partner]** and/or **Dependent Child(ren)** designated by the **Insured** as enrolled in **Academic Studies** regardless of the **Plan** chosen by the **Insured**.]

[**Dependent** means the **Insured's Spouse [/Domestic Partner]** and **Dependent Child(ren)**, as defined in this section. [A **Dependent** will only be a covered **Dependent** if a **Plan** covering **Dependents** is selected and all other conditions of coverage are satisfied.]]

[**Dependent Child(ren)** means the **Insured's** unmarried child(ren) and those of the **Insured's Spouse[/Domestic Partner]** who rely on the **Insured** for support, and are either: 1) less than [19 (nineteen)] years of age; 2) less than [25 (twenty-five)] years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental or physical handicap.]

**Student Expense** means those fees and expenses incurred or that would have been incurred by the **Tuition Payor** on behalf of a **Covered Person** for housing, transportation, and meal plan as charged by a school.

**Student Tuition** means the amount of money paid or to be paid, including administrative fees, by the **Tuition Payor** to an educational institution or school , including grammar schools, high schools, trade schools, university, or college. **Student Tuition** does not include housing or other living expenses.

**Tuition Expenses** means the actual unreimbursed amount of **School Tuition** incurred or that would have been incurred by the **Tuition Payor** on behalf of a **Covered Person** to attend the school for **Academic Studies** including expenses incurred for learning material such as books.

**Tuition Payor** means the person(s) or individual(s) named or designated in the Application or Enrollment form as the person(s) or individual(s) that is/are financially responsible for paying the **Tuition Expenses** for the **Covered Person** that is a full-time student of the educational institute school of the **Policyholder**.

[For purposes of this benefit only, the following additional exclusions apply:

Benefit does not apply to:

1. [Expenses previously reimbursed to the **Tuition Payor** or **Covered Person** through any employment tuition reimbursement program;]
2. [Academic Scholarships provided to the **Covered Person**.]
3. [Athletic Scholarships provided to the **Covered Person**.]
4. [Student loans made by the **Policyholder** to or on behalf of the **Tuition Payor** or the **Covered Person**. This does not include student loans made by a third party and facilitated by the **Policyholder**.]]

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_

# Accelerated Payment Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

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

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

In the event that an **Insured** is **Terminally Injured**, the **Insured** may be eligible to receive an Accelerated Payment Benefit. **We** will pay the applicable Accelerated Payment Benefit up to the Coverage Amount shown on the Schedule, provided the **Terminally Injured Insured**:

1. is covered under the **Policy**;
2. is under age [60 - 70]; and
3. provides **Us** with Proof of Loss of the **Terminal Injury**.

The **Insured** must request in writing that a portion of the Accidental Death Benefit be paid as an Accelerated Payment Benefit. However, if the **Insured** is incompetent or unable to provide a request for the Accelerated Payment Benefit, the **Insured's** legal guardian may submit the request. The amount of Accidental Death Coverage payable upon the **Terminally Injured Insured's** death will be reduced by any Accelerated Payment paid under this benefit.

The **Insured** may request a minimum Accelerated Payment Benefit Coverage Amount of [\$3,000, and a maximum of \$100,000]. However, in no event will the Accelerated Payment Benefit exceed [thirty (30%)] of the **Terminally Injured Insured's** Coverage Amount of Accidental Death Benefit. [This option may be exercised only once for each **Insured**.] The Accelerated Payment Benefit payment will be made to the **Insured** now instead of the **Insured's** beneficiary upon death.

[For example, if the **Insured** is covered under an Accidental Death Benefit for \$100,000 and is **Terminally Injured**, the **Insured** can request any portion of the amount of Accidental Death Benefit Coverage Amount from \$3,000 to \$30,000 to be paid now instead of to the **Insured's** beneficiary upon death. However, if the **Insured** decides to request only \$3,000 now, the **Insured** cannot request the additional \$27,000 in the future]. Any payments received under this rider may be taxable. The **Insured** should consult a personal tax advisor for further information.

The **Insured** must satisfy all the terms and conditions herein in order to receive an Accelerated Payment Benefit. If the **Insured** has executed an assignment of rights and interest with respect to the **Insured's** Accidental Death Benefit, in order to receive the Accelerated Payment Benefit, **We** must receive a release from the assignee before any benefits are payable.

**We** reserve the right to require satisfactory proof of **Terminal Injury** on an ongoing basis. Any diagnosis submitted must be provided by a **Physician**.

If the **Insured** does not submit Proof of Loss of **Terminal Injury**, or if the **Insured** refuses to be examined by a **Physician** licensed to practice in the United States, as **We** may require, then **We** will not pay an Accelerated Payment Benefit. If the **Insured** is diagnosed by a **Physician** as no longer **Terminally Injured** and:

1. is in an Eligible Class, coverage will remain in force, provided premium is paid;
2. is not in an Eligible Class, but the **Insured** continues to meet the definition of **Disabled**, coverage will remain in force, subject to the Change or Waiver condition within the **Policy**; and
3. Accelerated Benefit amounts previously paid to the **Insured** must be returned.

The Coverage Amount of the Accidental Death Benefit will be reduced by the Accelerated Payment Benefit paid.

For purposes of this rider only, the following additional definitions apply:

**Disabled** means that due to the **Terminal Injury** the **Insured**:

1. is unable to perform the material and substantial duties of any occupation to which the **Insured** is suited by education, training, and experience; [or
2. with respect to a **Spouse**[/**Domestic Partner**] who is unemployed, his or her ability to engage in the normal and customary activities of a person of like age and gender in good health.]

**Terminal Injury** or **Terminally Injured** means the **Covered Injury** that resulted in the **Insured** having a life expectancy of [nine (9)] months or less.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_

# Accident Medical Expense - Indemnity Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Blanket Accident Insurance Policy

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

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss** under this **Policy**, **We** will pay the following benefits as applicable per **Insured** for each **Covered Accident**. The **Covered Injury** must be independent of **Sickness** or the medical or surgical treatment of **Sickness**, or of any cause other than a **Covered Accident**. A **Covered Loss** must also occur while coverage is in force.

[Emergency Room Treatment

**We** will pay [\$500] once per [forty-eight (48)] hour period per **Covered Accident**, per **Insured** when that **Insured** receives emergency room treatment for **Injuries** sustained in a **Covered Accident**. This benefit is for treatment by a **Physician** or treatment received in a **Hospital** emergency room. Treatment must be received within [forty-eight (48)] hours of the **Accident** for benefits to be payable.]

[X-Rays Related to an **Accident**

**We** will pay [\$500] once per **Covered Accident** per **Insured** when an **Insured** requires an X-ray while receiving emergency room treatment in a **Hospital** for **Injuries** sustained in a **Covered Accident**. This benefit is not for X-rays received in a **Physician's** office. [The X-Ray Benefit is not for exams listed in the Diagnostic Testing & Exams Benefit.]

[Emergency Room Follow Up Treatment

**We** will pay [\$500] for one treatment per day, up to a maximum of [three (3)] treatments per **Covered Accident** for an **Insured** when that **Insured** receives emergency room treatment for **Injuries** sustained in a **Covered Accident** and later requires additional treatment in addition to the original emergency room treatment administered in the first [forty-eight (48)] hours following the **Covered Accident**. The emergency room follow up treatment must begin within [thirty (30)] days of the **Covered Accident** or discharge from the **Hospital**, the **Hospital Confinement** which must be related to the same **Covered Accident** for which the subsequent treatment is being sought. Treatments must be furnished by a **Physician** in a **Physician's** office or in a **Hospital** on an outpatient basis. This benefit is not payable for days wherein additional emergency room treatment benefits are payable.]

[Accident Hospitalization

**We** will pay [\$500] once per period of **Hospital Confinement** or [\$500] once when an **Insured** is admitted directly to an **Intensive Care Unit** [two (2)] time(s) per calendar year per **Insured** when that **Insured** is admitted for a **Hospital Confinement** of at least [eighteen (18)] hours for treatment of **Injuries** sustained in a **Covered Accident** or if an **Insured** is admitted directly to an **Intensive Care Unit** of a **Hospital** for treatment of **Injuries** sustained in a **Covered Accident**. **Hospital Confinements** must start within [sixty (60)] days of the **Covered Accident**.]

[Specific Coverage Amount for Accidental Injuries

**We** will pay [\$5,000] for the following **Covered Injuries**:

[Dislocation Benefit

1. **Dislocation** (reduced under general anesthesia):

**We** will pay for no more than [two (2)] **Dislocations** per **Covered Accident** per **Insured**.

Benefits are payable for each **Dislocation** for each joint but for only the first **Dislocation** of a joint.

Benefit:

Joint Area	Open Reduction	Closed Reduction
A. Hip	[\$2,500]	[\$500]
B. Knee	[\$2,500]	[\$500]
C. Shoulder	[\$2,500]	[\$500]
D. Collar Bone	[\$2,500]	[\$500]

E. Ankle or Foot	[\$2,500]	[\$500]
F. Lower Jaw	[\$2,500]	[\$500]
G. Wrist	[\$2,500]	[\$500]
H. Elbow	[\$2,500]	[\$500]
I. Toe	[\$2,500]	[\$500]
J. Finger	[\$2,500]	[\$500]

If a **Dislocation** is reduced with local anesthesia, or no anesthesia by a **Physician** or a **Physician Assistant**, **We** will pay [fifty (50)] percent of the amount shown for the closed **Reduction Dislocation**.]

[2. Burn Benefit

For burns arising out of a **Covered Accident** and treated by a **Physician** within [forty-eight (48)] hours after that **Covered Accident**, **We** will pay the following:

Benefit:

Body Surface Area	2 <sup>nd</sup> Degree	3 <sup>rd</sup> Degree
A. Less than 50 square centimeters	[\$2,500]	[\$5,000]
B. More than 100 but less than 150 square centimeters	[\$2,500]	[\$5,000]
C. More than 150 but less than 200 square centimeters	[\$2,500]	[\$5,000]
D. More than 200 but less than 250 square centimeters	[\$2,500]	[\$5,000]
E. More than 250 but less than 300 square centimeters	[\$2,500]	[\$5,000]
F. More than 300 square centimeters	[\$2,500]	[\$5,000]

]

[3. Skin Grafts

If an **Insured** receives up to [five (5)] skin graft(s) for a burn from a **Covered Accident**, **We** will pay a total of [seventy-five (75%)] of the Burn Benefit Coverage Amount **We** paid for the burn involved in addition to the amount paid for the Burn Benefit.]

[4. Eye Injuries

If an **Insured** sustains an **Injury** to an eye as a result of a **Covered Accident**, **We** will pay the following:

- a. Surgical repair [\$1,000]
- b. Removal of foreign body by a **Physician** [\$250].]

[5. Lacerations

If an **Insured** sustains a laceration as a result of a **Covered Accident**, provided the laceration is repaired within [forty-eight (48)] hours after the **Covered Accident** and repaired under the attendance of a **Physician**, **We** will pay the following:

Benefit:

Laceration	Coverage Amount
A. Laceration(s) not requiring sutures and treated by a <b>Physician</b> (total length of all lacerations)	[\$500]
B. Laceration(s) less than 5 centimeters in length (total of all lacerations)	[\$500]
C. Lacerations at least 5 centimeters in length but not more than 15 centimeters in length (total of all lacerations)	[\$500]
D. Lacerations over 15 centimeters in length (total of all lacerations)	[\$500]

]

[6. Fractures

**We** will pay for no more than [five (5)] **Fractures** per **Covered Accident**, per **Insured**. In the event of multiple fractures (more than [three (3)]) sustained by the same **Insured**, **We** will pay for the largest **Fracture** amount. However, **We** will pay [fifty (50%)] percent of the Coverage Amount shown for the closed **Reduction** for **Chip Fractures** and other **Fractures** not reduced by Open or Closed **Reduction**.

Benefit:

Fracture Area	Open Reduction	Closed Reduction
A. Hip	[\$15,000]	[\$7,500]
B. Leg	[\$15,000]	[\$7,500]
C. Hand (excluding fingers)	[\$15,000]	[\$7,500]
D. Foot (excluding heel/toes)	[\$15,000]	[\$7,500]
E. Wrist	[\$15,000]	[\$7,500]
F. Kneecap	[\$15,000]	[\$7,500]
G. Lower Jaw	[\$15,000]	[\$7,500]
H. Shoulder	[\$15,000]	[\$7,500]
I. Vertebrae (body of)	[\$15,000]	[\$7,500]
J. Pelvis (excluding coccyx)	[\$15,000]	[\$7,500]
K. Sternum	[\$15,000]	[\$7,500]
L. Upper Jaw	[\$15,000]	[\$7,500]
M. Upper Arm	[\$15,000]	[\$7,500]
N. Face (excluding nose)	[\$15,000]	[\$7,500]
O. Rib	[\$15,000]	[\$7,500]
P. Nose	[\$15,000]	[\$7,500]
Q. Heel	[\$15,000]	[\$7,500]
R. Finger	[\$2,500]	[\$1,000]
S. Coccyx	[\$10,000]	[\$7,500]
T. Toe	[\$2,500]	[\$1,000]
U. Vertebral Processes	[\$10,000]	[\$7,500]
V. Skull		
(i) Depressed	(i)[\$10,000]	(i)[\$7,500]
(ii) Simple	(ii)[\$10,000]	(ii) [\$7,500]

[7. Concussion:

If an **Insured** sustains a concussion as a result of a **Covered Accident**, **We** will pay [\$1,000] for each concussion for each **Insured**.]

[8. Emergency Dental Procedure:

If an **Insured** sustains a **Covered Injury** as a result of a **Covered Accident** requiring emergency dental work, **We** will pay the following benefits:

a. Broken tooth repaired with crown [\$750]

b. Broken tooth resulting in extraction [\$750]

Emergency dental work does not include false teeth such as dentures, bridges, veneers, partials, crowns, or implants. **We** will pay for no more than [two (2)] Emergency Dental Procedure benefit(s) per **Covered Accident**, per **Insured**.]

[9. Specified Surgical Procedures Arising from a Covered Accident:

If an **Insured** sustains a **Covered Injury** as a result of a **Covered Accident** and one of the specified surgical procedures is required, such surgical procedure must be performed within [one (1)] year(s) of the **Covered Accident**. [Two or more surgical procedures performed through the same incision will be considered one surgical procedure.] In the event of multiple procedures, **We** will pay for the most expensive procedure.

Benefit:

Surgical Procedure	Coverage Amount
A. Arthroscopy without surgical repair	[\$5,000]
B. Open abdominal (including exploratory laparotomy)	[\$5,000]

C. Cranial	[\$5,000]
D. Hernia	[\$5,000]
E. Thoracic surgery	[\$5,000]
F. Repair of:	[\$5,000]]
i. Tendons and/or ligaments	
ii. Torn rotator cuffs	
iii. Ruptured discs	
iv. Torn knee cartilages	

]

**[10. Non-Specified Surgical Procedures Arising from a Covered Accident:**

If an **Insured** sustains a **Covered Injury** as a result of a **Covered Accident** and a non- specified surgical procedure is required, such surgical procedure must be performed within [one (1)] year of **Covered Accident**. [Two or more surgical procedures performed through the same incision will be considered one surgical procedure.] In the event of multiple procedures, **We** will pay for the most expensive procedure. **We** will pay for the following:

- a. Miscellaneous surgery with general anesthesia [\$2,500]
- b. Other miscellaneous surgery with conscious sedation [\$2,500]]

**[Diagnostic Testing & Exams Benefit**

**We** will pay [\$2,500] [five (5)] time(s) per calendar year, per **Insured** when an **Insured** requires one of the following exams for **Injuries** sustained in **Covered Accident** and a charge is incurred: computerized tomography (CT scan), computerized axial tomography (CAT), magnetic resonance imaging (MRI), or electroencephalography (EEG). These exams must be performed in a **Hospital** or a **Physician's** office. [Exams listed in the Diagnostic Testing & Exams Benefit are not covered under the X-Ray Related to an **Accident** Benefit.]

**[Pain Management**

**We** will pay [\$2,500] no more than [five (5)] time(s) per **Covered Accident**, per **Insured** when an **Insured** is prescribed, receives, and incurs a charge for an epidural or other similar treatment administered for pain management in a **Hospital** or a **Physician's** office for **Injuries** sustained in a **Covered Accident**. This benefit is not for an epidural or other similar treatment administered during a surgical procedure [or for pain management associated with pregnancy].]

**[Physical Therapy and Rehabilitation**

**We** will pay [\$250] per treatment for [two (2)] treatment(s) per day, up to a maximum of [five (5)] treatment(s) per **Covered Accident**, per **Insured** when an **Insured** receives emergency treatment for **Injuries** sustained in a **Covered Accident** and later a **Physician** advises an **Insured** to seek treatment from a licensed **Physical Therapist**. Physical therapy must be for **Injuries** sustained in a **Covered Accident** and must start within [thirty (30)] days of the **Covered Accident** or discharge from the **Hospital**. The treatment must take place within [six (6)] month(s) after the **Covered Accident**. [The Physical Therapy and Rehabilitation Benefit are not payable on the same day that the Emergency Room Follow Up Treatment Benefit is payable.]

**[Durable Medical Equipment and Prosthetic Appliance**

**We** will pay [\$5,000] once per **Covered Accident**, per **Insured** when an **Insured** receives **Durable Medical Equipment**, prescribed by a **Physician**, as an aid in personal locomotion for **Injuries** sustained in a **Covered Accident**. Benefits are for the following types of equipment: a wheelchair, a leg brace, a back brace, a walker, and/or a pair of crutches. **We** will pay [\$5,000] once per **Covered Accident** per **Insured** when the **Insured** requires use of a **Prosthetic Appliance** as a result of **Injuries** sustained in a **Covered Accident**. This benefit is not intended to provide a benefit for the repair or replacement of **Prosthetic Appliance** already prescribed for the **Insured**, hearing aids, wigs, or dental aids, including false teeth.]

**[Blood, Plasma, and or Platelets**

**We** will pay [\$2,500] once per **Covered Accident** per **Insured** when that **Insured** receives blood, plasma, and/or platelets for the treatment of **Injuries** sustained in a **Covered Accident**. This benefit is not intended to pay for immunoglobulins or other similar treatments.]

**[Ambulance**

**We** will pay [\$500] when an **Insured** requires transportation by **Ambulance** and [\$5,000] when that **Insured** requires air ambulance transportation to a **Hospital** for **Injuries** sustained in a **Covered Accident**. Air Ambulance services must take place within [forty-eight (48)] hours of the **Covered Accident**. **Ambulance** transportation must be within [forty-eight (48)] hours of the **Covered Accident**. A licensed professional ambulance company must

provide the ambulance service. A licensed professional air ambulance company must provide the air ambulance service.]

[Transportation

**We** will pay [\$25] per round trip, up to three round trips per calendar year, per **Insured** per round trip to a **Hospital** when an **Insured** requires **Hospitalization** or **Hospital Confinement** for medical treatment due to an **Injury** sustained in a **Covered Accident**. This benefit may also be used; if a covered **Dependent Child** requires **Hospitalization** or **Hospital Confinement** for medical treatment due to an **Injury** sustained in a **Covered Accident**, if commercial travel is necessary and such **Dependent Child** is accompanied by a person **Related** to the **Insured**. This benefit is not for transportation to any **Hospital** located within a [fifty (50)]-mile radius from the site of the **Accident** or the residence of the **Insured**. The local attending **Physician** must prescribe the treatment requiring **Hospitalization** or **Hospital Confinement**, and the treatment must not be available locally. This benefit is not for transportation by ambulance or air ambulance to the **Hospital**.]

[Accommodations During Hospital Confinement

**We** will pay [\$50] per night, limited to one motel/hotel room per night, up to [five (5)] days per **Covered Accident** for one motel/hotel room for a member of the immediate family who accompanies an **Insured** who is admitted for **Hospitalization** or **Hospital Confinement** for the treatment of **Injuries** sustained in a **Covered Accident**. This benefit is only during the same period of time the injured **Insured** is confined to the **Hospital**. The **Hospital** and motel or hotel must be more than [fifty (50)] miles from the residence of the **Insured**.]

Limitations and Exclusions

For purposes of this rider only, the following additional exclusions apply:

1. **We** will not pay benefits for services rendered by a person **Related** to the **Insured**.
2. **We** will not pay benefits for treatment or loss due to **Sickness**, including
  - a. any bacterial, viral, or microorganism infection or infestation, or
  - b. any condition resulting from insect, arachnid, or other arthropod bites or stings; or
  - c. an error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure for any **Sickness**.
3. **We** will not pay benefits for cosmetic surgery or other elective procedures that are not **Medically Necessary** or are unrelated to the **Injury** caused by the **Covered Accident**.
4. **We** will not pay benefits for dental treatment except as a result of a **Covered Injury**.

For purposes of this rider only, the following additional definitions apply:

**Ambulance** means any publicly or privately owned surface, water or air vehicle, including a helicopter, that is specifically designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded. Ambulance does not include a surface, water or air vehicle that is owned and operated to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport.]

**Durable Medical Equipment** means equipment or apparatus of a type that is designed primarily for use, and used primarily, to assist persons suffering from illnesses or injuries that restrict their normal mobility and function and includes equipments such as a wheelchair or a hospital bed. It does not include items commonly used by persons that are not injured, even if the items can be used in the treatment of injury or can be used for rehabilitation or improvement of health such as a stationary bicycle or a spa.]

**Chip Fracture** means a **Fracture** in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached. It must be diagnosed by a **Physician** through the use of an X-ray or other similar diagnostic exam.

**Coma** means a continuous state of profound unconsciousness, diagnosed or treated after the **Insured's** Effective Date of coverage, lasting for a period of seven (7) or more consecutive days, and characterized by the absence of (1) spontaneous eye movements, (2) response to painful stimuli, and (3) vocalization. The condition must require intubation for respiratory assistance. **Coma** does not include medically induced coma.

**Dislocation** means a completely separated joint due to an **Injury**. The **Dislocation** must be diagnosed by a **Physician** [within seventy-two (72) hours] after the date of the **Injury** and require correction by a **Physician**.

**Fracture** means a break in a bone due to an **Injury** and that can be seen by X-ray or other similar diagnostic exam. The **Fracture** must be diagnosed by a **Physician** [within fourteen (14) days after the date of the **Covered Injury**] and require correction by a **Physician**.

**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 twenty-four (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 Confinement (Hospitalization)** means a stay by the **Insured** confined to a bed in a **Hospital** for which a room charge is made. The **Hospital Confinement** must be on the advice of a **Physician**, it must be **Medically Necessary**, and the result of **Injuries** sustained in a **Covered Accident** or for rehabilitative care and treatment for **Injuries** sustained in a **Covered Accident**. **Hospital Confinement** also means the period of **Hospital Confinement** that starts while this policy is in force. If the **Hospital Confinement** follows a previously covered **Hospital Confinement**, it will be deemed a continuation of the first **Hospital Confinement** unless (1) the later **Hospital Confinement** is the result of an entirely unrelated **Injury** or (2) the **Hospital Confinements** are separated by thirty (30) days or more. **Hospitalization** that begins prior to the end of one calendar year and continues into the next calendar year will be considered one **Hospital Confinement**.

**Injury** means a bodily **Injury** caused directly by a **Covered Accident**, independent of **Sickness**, disease, bodily infirmity, or any other cause, occurring on or after the **Insured's** Effective Date of coverage and while coverage is in force for the **Insured**.

**Intensive Care Unit (ICU)** means a specifically designated facility of the **Hospital** that provides the highest level of medical care and that is restricted to those patients who are critically ill or injured. Such facilities must be separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement. The **ICU** must be permanently equipped with special lifesaving equipment for the care of the critically ill or injured, and the patients must be under constant and continual observation by nursing staffs assigned exclusively to the **ICU** on a full-time basis. These units must be listed as **Intensive Care Units** in the current edition of the American Hospital Association Guide or be eligible to be listed therein. **ICU** includes Cardiac Intensive Care Units and Infant (Neonatal) Intensive Care Units.

**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**.

**Physical Therapist** means a licensed specialist in physical therapy other than a person **Related** to the **Insured**.

**Prosthetic Appliance** means a replacement or artificial substitution for a missing **Limb** or eye. This does not include a dental prosthetic device such as dentures or crowns.

**Reduction** means open (surgical) or closed (manipulative) repair of a **Fracture** or **Dislocation**.

**Rehabilitation Unit** means a unit of a **Hospital** providing coordinated multidisciplinary physical restorative services to inpatients under the direction of a **Physician** who is knowledgeable and experienced in rehabilitative medicine. Beds must be set up and staffed in a unit specifically designated for this service.

**Related** means [the **Insured's Spouse/Domestic Partner**] or other adult living with the **Insured**], sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.

**Sickness** means an illness, disease, infection, or any other abnormal physical condition, independent of **Injury**, occurring on or after the **Insured's** Effective Date of coverage and while coverage is in force for the **Insured Person**. Complications of Pregnancy will be covered to the same extent as a **Sickness**.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_



# Complications of Pregnancy Benefit

ZURICH AMERICAN INSURANCE COMPANY  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

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

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

If the **Insured** suffers a **Covered Complications of Pregnancy**, [other than a **Non-elective Cesarean Section**,] resulting from a **Covered Accident**, **We** will pay the [coinsurance percentage of the] **[Usual and Customary]** expenses for **Medically Necessary** Covered Medical Service(s) incurred up to the Coverage Amount as shown on the Schedule. [The Coverage Amount is the amount payable per calendar year for all **Covered Complications of Pregnancy** payable under the **Policy**.] This benefit is payable only for such **Covered Charges** incurred [after the Deductible, as shown on the Schedule, has been met and] on or after the date the **Insured** suffers the **Covered Complications**. [**Complications of Pregnancy Benefits** are in excess of all other valid and collectible Insurance.]

[If the **Covered Complication of Pregnancy** is a **Medically Necessary Non-elective Cesarean Section**, after the applicable **Deductible** has been met and on or after the date the **Non-elective Cesarean Section** is performed, benefits are payable on the same basis as any other **Covered Complications** for **Covered Charges** incurred, up to the Coverage Amount shown in the Schedule.]

[Additional Benefit

If the **Insured's** coverage terminates under this benefit solely due to the birth of a child, an Additional Benefit will be provided for [six (6)] [weeks][months] from the date of termination for [**Covered Complications**] [and] [post-partum depression] resulting solely from that **Covered Accident**. This benefit is payable only for such **Covered Charges** incurred [after the applicable **Deductible**, as shown on the Schedule, has been met and] on or after the date the **Insured** suffers the **Covered Complications**, subject to the Additional Benefit Coverage Amount shown on the Schedule. [The overall Coverage Amount for **Complications of Pregnancy** payable per calendar year will be reduced by the amount paid under this Additional Benefit.] Benefits provided under this rider are subject to all other terms and limitations of the **Policy**.]

For purposes of this rider only, the following additional definitions apply:

**Alcohol and Substance Abuse** means the overindulgence or dependence on a stimulant, depressant or other chemical substance, leading to effects that are detrimental to the individual's welfare or the welfare of others.

**Covered Complications of Pregnancy (Covered Complications)** means any of the following conditions requiring [treatment by a **Physician**] [**Hospital Confinement**] [when the pregnancy is not terminated] whose diagnoses are distinct from but adversely affected by pregnancy or caused by pregnancy, including:

1. acute nephritis;
2. nephrosis;
3. cardiac decompensation;
4. missed abortion; [and]
5. similar medical and surgical conditions of comparable severity;[and]
6. [**Non-Elective Cesarean Section**]; [and]
7. spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

**Covered Complications of Pregnancy** do not include false labor, occasional spotting, [**Physician**-prescribed rest during the period of pregnancy,] morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

[**Deductible** means the amount of **Usual and Customary Expenses** for **Medically Necessary** treatment of [**Covered Complications**][**Non-elective Cesarean Sections**] that must be incurred and paid by the **Insured** before [**Covered Complications**][**Non-elective Cesarean Section**] benefits become payable. The amount of the **Deductible** is shown in the Schedule. **Covered Complications of Pregnancy** benefits are not payable for charges applied to the **Deductible**.]

**Durable Medical Equipment** means equipment or apparatus of a type that is designed primarily for use, and used primarily, to assist persons suffering from illnesses or injuries that restrict their normal mobility and function and includes equipments such as a wheelchair or a hospital bed. It does not include items commonly used by persons that are not injured, even if the items can be used in the treatment of injury or can be used for rehabilitation or improvement of health such as a stationary bicycle or a spa.

**Experimental or Investigative Treatment** means treatment, a device or prescription medication which is recommended by a **Physician**, but is not considered by the medical community as a whole to be safe and effective for the condition for which the treatment, device, or prescription medication is being used, including any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice, and any items requiring federal or other government agency approval for which approval is not yet received at the time the services are rendered.

**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 (Hospital Confinement)** means admission to a **Hospital** as an inpatient [for at least twenty-four (24) consecutive hours] by a **Physician** for a **Covered Complication**. A **Hospital** stay that does not result in charges to the **Insured** is not a **Hospital Confinement** under this rider unless there is no charge because the **Hospital** is a United States government facility.

**Medically Necessary** means that the medical service or treatment:

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

[**Non-Elective Cesarean Section** means an unscheduled cesarean section due to an emergency which puts the life and health of the **Insured** or fetus in jeopardy.]

**Pre-existing Condition** means a condition for which an **Insured** received any diagnosis, medical advice or treatment or had taken any prescription medicines during the [six (6)] months immediately preceding the **Covered Complication** [unless the condition for which the prescribed medication is taken remains controlled without any change in the required prescription].

**Related** means [the **Insured's Spouse**/[**Domestic Partner**] or other adult living with the **Insured**], sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.

**[Usual and Customary Expense(s) (Covered Charges)** means an amount(s) that: (1) is made for a **Covered Complication of Pregnancy**, (2) 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] (3) does not include charges that would not have been made if no insurance existed [and (4) 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.]

Termination of coverage will not affect a claim for a covered loss that occurred while the **Insured's** coverage was in force under this **Policy**.

#### **EXCLUSIONS:**

For purposes of this rider only and in addition to the General Exclusions in Section IV of the **Policy**, **We** will not provide coverage for any of the following:

- [1. routine examinations for pregnancy screening and testing.]
- [2. routine physical examination and related medical services.]
- [3. post-partum depression, except as specifically provided in the rider.]
- [4. rental of **Durable Medical Equipment** where the total rental expense exceeds the usual purchase expense for similar equipment in the locality where the expense is incurred (if **Complications of Pregnancy** benefits for rental of **Durable Medical Equipment** are expected to exceed the usual purchase expense for similar equipment in the locality where the expense is incurred, **We** will consider such purchase expense as a **Covered Charge** in lieu of such rental expense).]
- [5. personal comfort or convenience items, such as but not limited to **Hospital** telephone charges, television rental, or guest meals while confined in a **Hospital** [or for items taken away or home from the **Hospital**, [including but not limited to crutches, wheel chairs and walkers] [except **Durable Medical Equipment**]].]
- [6. expenses incurred for psychological or psychiatric counseling of any kind or any expense for treatment of mental or nervous diseases or disorders.]
- [7. any expenses for a **Pre-existing Condition**.]
- [8. elective abortion.]
- [9. elective or cosmetic, plastic or restorative surgery.]
- [10. any condition for which the **Insured** is entitled to benefits under any mandatory no-fault automobile insurance.]
- [11. charges that are payable under automobile medical benefits [in excess of [\$5000]].]
- [12. the cost of actual procedures relating to the testing, harvesting, and implantation of human eggs (oocytes).]
- [13. care, treatment, or services provided by any person **Related** to the **Insured**.]
- [14. **Experimental or Investigative Treatment** or procedures.]
- [15. diagnostic tests or treatment, except due to a **Complication of Pregnancy**.]
- [16. care, treatment or services provided by persons retained or employed by the **Policyholder**; or for supplies, prescriptions or medicines paid for or reimbursable for the **Policyholder**, or for which a charge is not made.]
- [17. normal pregnancy or child birth.]
- [18. treatment for a newborn child.]
- [19. treatment for in vitro fertilization, infertility, fertility studies, sexual transformation, sexual dysfunction.]

- [20. any expenses, services or treatment for any form of food supplement or augmentation (unless **Medically Necessary**), or for any exercise program for weight control, whether for obesity or any other diagnosis and whether by diet, injection of any fluid, or use of any medications or surgery of any kind.]
- [21. sexually transmitted diseases, including, but not limited to: herpes, gonorrhea, syphilis, cytomegalovirus, or any disability attributable, directly or indirectly, to Human Immunodeficiency Virus (HIV), and/or related illness including Acquired Immune Deficiency Syndromes (AIDS), or any mutant derivative thereof.]
- [22. non-prescription drugs which include, but are not limited to: vitamins, tonic, nutritional supplements, biochemical or herbal remedies.]
- [23. any loss incurred while outside the United States, its territories or Canada.]
- [24. **Alcohol and Substance Abuse.**]
- [25. riding in or driving any type of motor vehicle as part of a speed contest or scheduled race, including testing such vehicle on a track, speedway or proving ground.]
- [26. any action that may pose a health risk to the fetus, including, but not limited to: handling or changing cat litter, smoking cigarettes or remaining in the presence of secondhand smoke for extended periods of time.]
- [27. engaging in high-impact sports or any other similar activities that may pose a health risk to the fetus, including but not limited to: mountaineering, rappelling, horsemanship, rafting, sky-diving, bungee cord jumping.]
- [28. undergoing x-rays (except on an emergency basis) or chiropractic treatment without the prior written approval of a **Physician.**]
- [29. obtaining any permanent body tattooing or piercing any part of the **Insured's** body.]
- [30. use of any illegal drugs or use of any non-prescription medications or any prescription drug, narcotic, or hallucinogen, without consent of a **Physician** or in excess of the approved dosage]
- [31. **Complications of Pregnancy** arising from travel outside of the **Insured's** state of residence during the final trimester of pregnancy.]

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_

SERFF Tracking Number: ZURC-128142480 State: Arkansas  
 Filing Company: Zurich American Insurance Company State Tracking Number:  
 Company Tracking Number: CW AH 34189  
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness  
 Product Name: Blanket Affinity/MCM 1.2 Riders for Other Groups  
 Project Name/Number: /CWAH 34189

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Disapproved	05/02/2012
<b>Comments:</b>		
<b>Attachment:</b> U-BMC-300 Certificate of Readability.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Disapproved	05/02/2012
<b>Comments:</b> The Enrollment form was filed and approved under your Department Number 49785 effective 11/28/2011. Form number is U-BMC-303-B AR (08/11)		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> PPACA Uniform Compliance Summary	Disapproved	05/02/2012
<b>Bypass Reason:</b> Not applicable		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Statement of Variables for Arkansas	Disapproved	05/02/2012
<b>Comments:</b>		
<b>Attachment:</b> U-BMC-3003-A AR - Statement of Variables.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Red-Lined Form	Disapproved	05/02/2012

*SERFF Tracking Number:*      *ZURC-128142480*                      *State:*                      *Arkansas*  
*Filing Company:*              *Zurich American Insurance Company*              *State Tracking Number:*  
*Company Tracking Number:*      *CW AH 34189*  
*TOI:*                      *H04 Health - Blanket Accident/Sickness*              *Sub-TOI:*                      *H04.000 Health - Blanket Accident/Sickness*  
*Product Name:*              *Blanket Affinity/MCM 1.2 Riders for Other Groups*  
*Project Name/Number:*              */CWAH 34189*

**Comments:**

**Attachment:**

U-BMC-304-B CW - Admin Change Endorsement REDLINED.pdf

# Certificate of Readability for Arkansas



Zurich American Insurance Company

I have reviewed or supervised the preparation of the attached policy forms. I hereby certify that to the best of my knowledge, information, and belief, these policy forms comply with the minimum readability standards required by your State Insurance Code.

The policy forms listed below have achieved the following Flesch Scores using the Flesch Reading Ease software published by Micro Power & Light Co.:

Form Number	Title	Flesch Score
U-BMC-304-B CW (09/11)	Administrative Change Endorsement	48
U-BMC-308-A AR (09/11)	Eligibility of Dependents Benefit	51
U-BMC-309-A CW (09/11)	Additional Accidental Dismemberment [and Covered Loss of Use] [and Plegia] for Dependent Children Benefit	48
U-BMC-318-A CW (09/11)	Critical Burn Benefit	55
U-BMC-320-A AR (09/11)	Permanent Temporary Total Disability Benefit	38
U-BMC-323-A AR (09/11)	After School Care Benefit	49
U-BMC-324-A CW (09/11)	Inflation Benefit	40
U-BMC-331-A CW (09/11)	HIV Occupational Accident Benefit	48
U-BMC-347-A CW (09/11)	Continuation of Insurance Benefit	53
U-BMC-348-A AR (09/11)	Day Care Benefit	53
U-BMC-349-A CW (09/11)	Hearing Aid or Prosthetic Appliance Benefit	51
U-BMC-353-A CW (09/11)	Emergency [Transportation] [and] [Treatment] [and] Hospital Cash Benefit	37
U-BMC-361-A AR (09/11)	Traumatic Brain Injury Benefit	48
U-BMC-371-A CW (09/11)	Home Alteration and Vehicle Modification Benefit	42
U-BMC-372-A CW (09/11)	Natural Disaster Benefit	58
U-BMC-373-A CW (09/11)	[Occupational] [or] [Voluntary Activity] Hepatitis Benefit	36
U-BMC-374-A CW (09/11)	Recuperation Benefit	57
U-BMC-375-A CW (09/11)	Student [Tuition] [and] [Expense] Reimbursement Benefit	38
U-BMC-376-A CW (09/11)	Accelerated Payment Benefit	39
U-BMC-377-A CW (09/11)	Accident Medical Expense Indemnity Benefit	49
U-BMC-378-A AR (09/11)	Complications of Pregnancy Benefit	32

Although some of the forms listed above may not have achieved the minimum readability standards required by your State Insurance Code, we respectfully request approval based on our belief that:

1. the lower score provides a more accurate reflection of the readability of the form(s); and
2. the lower score is warranted by the nature of the particular form(s) or type or class of form(s).

Signature: 

Officer: Lisa Plante

Title: Head of A&H Product Management

Date: October 24, 2011

# Statement of Variables for Arkansas



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

Each bracketed benefit or provision will be in or out (in if needed, otherwise omitted). Each bracketed phrase will be in or out. In each instance, the Policy Schedule will be amended to reflect the limits shown for the Benefit.

## **ADMINISTRATIVE CHANGE ENDORSEMENT - U-BMC-304-B CW (09/11)**

<p>[This endorsement will be used to make the following types of administrative changes to the <b>Policy</b>:</p> <ol style="list-style-type: none"><li>1. Policyholder's Name or Address;</li><li>2. Addition or deletion of subsidiaries or affiliates of the Policyholder;</li><li>3. Changes to the class(es) of eligible persons;</li><li>4. Addition or deletion of Benefit Riders;</li><li>5. Increase or decrease in Coverage Amount(s); or</li><li>6. Renewal of the Policy.]</li></ol>	<p>This endorsement will be used to make administrative changes to the Policy.</p>
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ELIGIBILITY OF DEPENDENTS - U-BMC-308-A AR (09/11)

Section II Eligibility and Effective Dates of Insurance is amended to include the following:

An **Insured** may elect to cover their eligible **Dependents**. An eligible **Dependent** includes the **Insured's Spouse[/Domestic Partner]** and the **Insured's Dependent Child(ren)**, [and] [his or her **Spouse's Dependent Child(ren)**] [, and his or her **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 this **Policy**. If the **Insured** and his or her **Spouse[/Domestic Partner]**, or former **Spouse[/Domestic Partner]**, are both **Insureds** under this **Policy**, only one may select a **Plan** covering their mutual **Dependents**.

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

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

[A child of an **Insured** born while this **Policy** is in force is covered from the moment of birth for a period of sixty (60) days. An adopted newborn child of an **Insured** is covered from the moment of birth for a period of sixty (60) days After this time, the child will remain covered only if the **Insured** has provided written notice of birth or filing of a petition for adoption to the **Policyholder** and pays the required premium due, if any.]

[A newly adopted child of an **Insured** is covered from the moment of adoption or the date of filing of a petition for adoption, for a period of sixty (60) days. After this time, the child will remain covered only if the **Insured** has provided written notice to the **Policyholder** of the adoption or filing of a petition for adoption, and pays the required premium due, if any.]

[All insurance for a **Dependent** will terminate on the earliest of the following:

1. On the date that the **Policy** is terminated;
2. On any premium due date if the premium is not received prior to the end of the Grace Period;
3. On the date the **Dependent** reaches age [seventy (70)]; or
4. On the first premium due date following the date the person no longer qualifies as a **Dependent**.]

Termination of the **Policy** or of any **Insured's** coverage will be without prejudice to any claim which commenced prior to the effective date of termination.

[/Domestic Partner] In all instances, will be in or out. [and] will be in or out. [his or her **Spouse's Dependent Child(ren)**] [, and his or her **Domestic Partner's Dependent Child(ren)**] will be in or out.

[or] This will be in or out.

[; or][.] This will be in or out.

This will be in or out.

This will be in or out.

This will be in or out. If in,

This will be in or out. If in,

[seventy (70)] The range will be 50 to 85.

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

<u>Plan Selected</u>	<u>Spouse</u>	<u>[/Domestic Partner]</u>	<u>% Child(ren)</u>
Spouse[/Domestic Partner] only:	[50%]		0%
Dependent Child(ren) only:	0%		[15%]
Spouse[/Domestic Partner] and Dependent Child(ren);	[40%]		[10%]

For purposes of this rider, the following additional definitions apply :

**[Dependent]** means the **Insured's Spouse** **[/Domestic Partner]** and **Dependent Child(ren)**, as defined in this section. [A **Dependent** will only be a covered **Dependent** if a **Plan** covering **Dependents** is selected and all other conditions of coverage are satisfied.]

**[Dependent Child(ren)]** means the **Insured's** unmarried child(ren) and those of the **Insured's Spouse** **[/Domestic Partner]** who rely on the **Insured** for support, and are either: 1) less than [nineteen (19)] years of age; 2) less than [twenty-five (25)] years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental or physical handicap.]

**Related** means [the **Insured's Spouse** **[/Domestic Partner]** or other adult living with the **Insured**], sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

This will be in or out.

**[/Domestic Partner]** will be in or out.

The range will be 0% to 100%.

The range will be 0% to 100%.

The range will be 0% to 100%

This will be in or out. If in,

This will be in or out.

This will be in or out. If in,

[nineteen (19)] the range will be 1 to 26.

[twenty-five (25)] the range will be 1 to 50.

[the **Insured's Spouse** **[/Domestic Partner]** or other adult living with the **Insured**] will be in or out. If in **[/Domestic Partner]** will be in or out.

[not] will be in or out.

**ADDITIONAL ACCIDENTAL [DISMEMBERMENT] [AND COVERED LOSS OF USE] [AND PLEGIA] FOR DEPENDENT CHILDREN BENEFIT - U-BMC-309-A CW (09/11)**

<p><b>ADDITIONAL ACCIDENTAL [DISMEMBERMENT] [AND COVERED LOSS OF USE] [AND PLEGIA] FOR DEPENDENT</b></p> <p>If an <b>Insured</b> selects a <b>Plan</b> covering his or her eligible <b>Dependent Child(ren)</b>, and a <b>Covered Dependent Child</b> suffers a <b>Covered Injury</b> resulting in a <b>Covered Loss</b>, which is payable under the Accidental [Dismemberment] [and] [Covered Loss of Use] [and Plegia] Benefit, <b>We</b> will pay the <b>Insured</b> an additional benefit which will be equal to the Coverage Amount provided by the Accidental [Dismemberment] [and] [Covered Loss of Use] [and Plegia] Benefit.</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the <b>Policy</b>.</p>	<p><b>[DISMEMBERMENT] [AND COVERED LOSS OF USE] [AND PLEGIA]</b> will be in or out.</p> <p>[Dismemberment] [and] [Covered Loss of Use] [and Plegia] these will be in or out.</p> <p>[Dismemberment] [and] [Covered Loss of Use] [and Plegia] these will be in or out.</p> <p>[not] will be in or out.</p>
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**CRITICAL BURN BENEFIT - U-BMC-318-A CW (09/11)**

If an **Insured** suffers a **Covered Injury** that is a **Critical Burn** resulting in a **Covered Loss** as a result of a **Covered Accident**, **We** will pay a Coverage Amount as shown on the Schedule, provided:

1. the **Insured** received [second degree or higher] burns over at least [25%] of his or her body[; and][.]
2. [within [three hundred sixty-five (365)] days of the **Covered Accident**, the **Insured** has undergone reconstructive surgery to treat the burned areas of the body.]

For the purposes of this rider only, **Critical Burn** means cosmetic disfigurement of the surface of a body area due to a **Covered Injury** [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).]

This rider is [not] subject to the limitations in Section V. General Limitations of the **Policy**.

[second degree or higher]. The severity of the burn will be inserted. [twenty-five (25%)] the range will be 10% to 80%. [; and] [.] these will be in or out.

This will be in or out. If in, [three hundred sixty-five (365)] the range will be 90 - 365 days.

This will be in or out.  
This will be in or out.

[not] will be in or out.

[PERMANENT] [TEMPORARY] TOTAL DISABILITY BENEFIT U-BMC-320-A AR (09/11)

<p>[PERMANENT] [TEMPORARY] Total Disability Benefit</p> <p>If an <b>Insured</b> suffers a <b>Covered Injury</b> resulting in a <b>Covered Loss</b> that renders the <b>Insured</b> [Permanently] [Temporarily] <b>Totally Disabled</b>, <b>We</b> will pay a [Permanent][Temporary] Total Disability Benefit provided that the <b>Insured</b> becomes [permanently][temporarily] <b>Totally Disabled</b> within [three hundred sixty-five (365)] days of the <b>Covered Injury</b> and the [permanent][temporary] <b>Total Disability</b> continues for [twelve (12)] consecutive months.</p> <p>The [monthly] [lump sum] amount payable under this benefit will be equal to the Coverage Amount shown in the Schedule. [The payments under this benefit will cease at the earliest of the following times:</p> <ol style="list-style-type: none"><li>1. <b>We</b> make [sixty (60)] payments under this benefit;</li><li>2. the <b>Insured</b> is no longer <b>Totally Disabled</b>;</li><li>3. the <b>Insured</b> dies.</li></ol> <p>Payments will begin on the thirty-first (31<sup>st</sup>) day of <b>Total Disability</b> and will continue for as long as the <b>Insured</b> is [permanently][temporarily] <b>Totally Disabled</b>, but will not exceed the <b>Benefit Period</b> of [sixty (60)] months.] As a condition of coverage, <b>We</b> must receive proof of continuing <b>Total Disability</b> on a regular basis.]</p> <p>Successive periods of <b>Total Disability</b> arising out of the same <b>Covered Injury</b> will be considered one <b>Total Disability</b> if they are separated by a period of less than [six (6)] months.</p> <p>For the purposes of this rider only, the following definitions apply:</p> <p>[<b>Benefit Period</b> means the time period that benefits are payable under this benefit subject to any other restrictions or limitations in the <b>Policy</b>.]</p> <p><b>Total Disability and Totally Disabled</b> means disability that:</p> <ol style="list-style-type: none"><li>1. prevents an <b>Insured</b> from performing the material and substantial duties of any occupation for which the <b>Insured</b> is qualified by reason of education, training, or experience [or if for an <b>Insured</b> who is not employed means that the person is unable to engage any of the usual activities of a person of like age and sex whose health is comparable to that of the <b>Insured</b>] immediately prior to the <b>Covered Accident</b>; and</li></ol>	<p>[PERMANENT][TEMPORARY] will be in or out.</p> <p>[Permanently] [Temporarily] will be in or out. [Permanent] [Temporary] will be in or out.</p> <p>[permanently] [temporarily] will be in or out. [three hundred sixty-five (365)] the range will be 90-730 [permanently] [temporarily] will be in or out. [twelve (12)] This will be in if [permanent] is in; otherwise it will be omitted. If in, the range will be six (6) to twelve (12)</p> <p>[monthly] [lump sum] will be in or out. This will be in or out. If in:</p> <p>[sixty (60)] the range will be 6 – 60</p> <p>[permanently] [temporarily] will be in or out.</p> <p>[sixty (60) months] the range will be six (6) to sixty (60)</p> <p>[six (6)] the range will be 3-12.</p> <p>This will be in or out.</p> <p>This will be in or out.</p>
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2. requires the **Continuous Care** and treatment of a **Physician**.

If the **Insured** does not adhere to the treatment plan the **Physician** prescribes relating to his or her disabling condition, the **Insured** shall not qualify for the [Permanent][Temporary] Total Disability Benefit. The **Insured** shall not qualify for **Total Disability** if the **Insured** engages in any activity which results in earned income.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

[Permanent] [Temporary] will be in or out.

[not] will be in or out.

AFTER SCHOOL CARE BENEFIT - U-BMC-323-A AR (09/11)

If an **Insured** [selects a **Plan** covering his or her **[Dependents][Dependent Child(ren)]** and the **Insured** or his or her **Spouse [Domestic Partner]**] suffers a **Covered Injury** resulting in a **Covered Loss** which is payable under the [Accidental Death [and Accidental Dismemberment]] Benefit, **We** will reimburse the charges actually incurred for the after school care for each **Dependent Child**, who is [ten (10)] years old or less, up to the Coverage Amount shown on the Schedule.

[If the **Insured** and his or her **Spouse/Domestic Partner**] both die as a result of the same **Covered Injury**, and **We** pay a[n] [Accidental Death] Coverage Amount on the **Insured** and his or her **Spouse [Domestic Partner]**, only the **Insured's** Coverage Amount will be used to calculate the amount applicable under this benefit.]

This benefit will be paid each year for [four (4)] consecutive years if the **Dependent Child(ren)** [is][are] under age [ten (10)] at the time of each payment.

For purposes of this rider only, the following additional definition applies:

**Related** means [the **Insured's Spouse/Domestic Partner**] or other adult living with the **Insured**, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

[selects a **Plan** covering his or her **[Dependents][Dependent Child(ren)]** and the **Insured** or his or her **Spouse [Domestic Partner]**] will be in or out. If in, **[Dependents][Dependent Child(ren)]** will be in or out. If in, **[Domestic Partner]** will be in or out. [Accidental Death [and Accidental Dismemberment]] will be in or out. If in, [and Accidental Dismemberment] will be in or out. [ten (10)]. The range will be 4 – 15. The amount of reimbursement will range from \$100 - \$100,000.

This will be in or out. If in, **[Domestic Partner]** will be in or out. [n] will be in or out. [Accidental Death] will be in or out. **[Domestic Partner]** will be in or out.

[four (4)]. The range will be 1 – 8 [is][are] will be in or out. [ten (10)]. The range will be 4 – 15

[the **Insured's Spouse/Domestic Partner**] or other adult living with the **Insured**] will be in or out. If in **[Domestic Partner]** will be in or out.

[not] will be in or out.

**INFLATION BENEFIT - U-BMC-324-A CW (09/11)**

<p>If an <b>Insured</b> sustains a <b>Covered Injury</b> that results in a <b>Covered Loss</b> payable under the [Accidental Death [and Accidental Dismemberment]] Benefit, the Inflation Benefit will provide an inflation adjustment to the Coverage Amount.</p>	<p>[Accidental Death [and Accidental Dismemberment]] will be in or out. If in, [and Accidental Dismemberment] will be in or out.</p>
<p>The Inflation Benefit is the <b>Insured's</b> Coverage Amount at the time of claim, multiplied by the product of:</p>	
<ol style="list-style-type: none"><li>1. the Inflation Benefit Percentage as shown on the Schedule; and</li><li>2. one (1) credited year for every two (2) years of continuous coverage under the <b>Policy</b> prior to the <b>Covered Loss</b>; to a maximum of [ten (10)] multiplied by the injured <b>Insured's</b> original Coverage Amount. [(Coverage Amount) x (Benefit Percentage x Years of Credited Coverage) = Inflation Benefit Coverage Amount.]</li></ol>	<p>[ten (10)]. The range will be 1 - 20.</p>
<p>[If an <b>Insured</b> increases the Coverage Amount, <b>We</b> will apply the Inflation Benefit separately to each additional increase under the <b>Policy</b>. Likewise, if an <b>Insured</b> decreases the Coverage Amount, <b>We</b> will correspondingly reduce any Inflation Benefit that was previously increased.]</p>	<p>This will be in or out.</p>
<p>This rider is [not] subject to the limitations in Section V General Limitations of the <b>Policy</b>.</p>	<p>[not] will be in or out.</p>

HIV OCCUPATIONAL ACCIDENT BENEFIT - U-BMC-331-A CW (09/11)

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss** while performing his or her job related duties, which causes him or her to acquire and test positive within [three hundred sixty-five (365)] days of such **Covered Accident** for Human Immunodeficiency Virus (HIV) and/or AIDS and related complex (ARC), **We** will pay an HIV Occupational Accident Benefit. Such HIV Occupational Accident Benefit will be equal to the Coverage Amount shown on the Schedule. The HIV Occupational Accident Benefit will be paid in [twenty-four (24)] equal monthly installments.

[three hundred sixty-five (365)] The range will be 30 - 720.

[twenty-four (24)] The range will be 2 - 60

If the initial test is negative, and the **Insured** subsequently tests positive for HIV, AIDS or ARC within [three hundred sixty-five (365)] days of the **Covered Accident**, **We** will begin monthly payments on the first day of the month following receipt of the report indicating positive test results.

[three hundred sixty-five (365)] The range will be 30 - 720.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

[not] will be in or out.

**CONTINUATION OF INSURANCE BENEFIT U-BMC-347-A CW (09/11)**

<p>If the <b>Insured</b> [selects a <b>Plan</b> covering his or her <b>Spouse[/Domestic Partner]]</b> [and <b>Dependent Child(ren)</b>] and the <b>Insured</b>] suffers a <b>Covered Injury</b> resulting in a <b>Covered Loss</b>, which is payable under the Accidental Death Coverage, provided there are no premium payments in arrears, all benefits under this <b>Policy</b> which were in force on the date of the loss will continue with respect to the <b>Insured's</b> eligible <b>Dependents</b> for [three hundred sixty-five (365)] days after the date of loss with no additional premium payments.</p> <p>For purposes of this rider only, insurance for eligible <b>Dependents</b> terminates on the earliest of:</p> <ol style="list-style-type: none"> <li>1. [three hundred sixty-five (365) days] after the date of <b>Covered Loss</b>;</li> <li>2. the first premium due date after the <b>Dependent</b> no longer qualifies as an <b>Insured</b>;</li> <li>3. [for the covered <b>Spouse[/Domestic Partner]</b>, the date the covered <b>Spouse[/Domestic Partner]</b> reaches age [seventy (70)].]</li> </ol> <p>For purposes of this rider only, the following additional definitions apply:</p> <p><b>Dependent(s)</b> means an <b>Insured's Spouse</b> [/<b>Domestic Partner</b>] and <b>Dependent Child(ren)</b>, as defined in this section. [The <b>Dependent</b> will only be a covered <b>Dependent</b> if a <b>Plan</b> covering <b>Dependents</b> is selected.]</p> <p><b>Dependent Child(ren)</b>, means the unmarried child(ren) of the <b>Insured</b>, [and] [the unmarried child(ren) of his or her <b>Spouse[/Domestic Partner]]</b> [and the unmarried child(ren) as defined in the <b>Policyholder's</b> [medical] plan as on file and approved by <b>Us</b>] who rely on the <b>Insured</b> for [more than fifty (50% ) of] their support, and are either: 1) less than [nineteen (19)] years of age; 2) less than [twenty-five (25)] years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental or physical handicap. [The <b>Dependent Child(ren)</b> will only be covered <b>Dependent Child(ren)</b> if a <b>Plan</b> covering <b>Dependent Child(ren)</b> is selected.]</p> <p><b>Related</b> means [the <b>Insured's Spouse[/Domestic Partner]</b> or other adult living with the <b>Insured</b>], sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.</p> <p><b>Spouse</b> means the <b>Insured's</b> legally married <b>Spouse</b> [under age seventy (70)]. [A <b>Spouse</b> will only be a <b>Covered Spouse</b> if a <b>Plan</b> covering the <b>Insured's Spouse</b> is selected.]</p>	<p>[selects a <b>Plan</b> covering his or her <b>Spouse[/Domestic Partner]]</b> [and <b>Dependent Child(ren)</b>] and the <b>Insured</b>] These will be in or out.</p> <p>[three hundred sixty-five (365) days] The range will be 90-365.</p> <p>[three hundred sixty-five (365) days] The range will be 90-365.</p> <p>This will be in or out. If in, [/<b>Domestic Partner</b>] this will be in or out. [seventy (70)] the range will be 50 - 85.</p> <p>[/<b>Domestic Partner</b>] this will be in or out. This will be in or out.</p> <p>[and] will be in or out. [the unmarried child(ren) of his or her <b>Spouse[/Domestic Partner]]</b> will be in or out. If in, [/<b>Domestic Partner</b>] will be in or out. [and the unmarried child(ren) as defined in the <b>Policyholder's</b> [medical] plan as on file and approved by <b>Us</b>] will be in or out. If in, [medical] will be in or out. [more than fifty (50%) of] will be in or out. [nineteen (19)] the range will be 1 to 26. [twenty-five(25)] the range will be 1 to 50. This will be in or out.</p> <p>[the <b>Insured's Spouse[/Domestic Partner]</b> or other adult living with the <b>Insured</b>] will be in or out. If in [/<b>Domestic Partner</b>] will be in or out.</p> <p>[under age seventy (70)]. The range will be 50 to 85 This will be in or out.</p>
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This rider is [not] subject to the limitations in Section V  
General Limitations of the **Policy**.

[not] will be in or out.

DAY CARE BENEFIT - U-BMC-348-A AR (09/11)

If an **Insured** [selects a **Plan** covering his or her **Dependents** and an **Insured** or his or her covered **Spouse[/Domestic Partner]**] suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Death Benefit, **We** will pay an additional benefit for day care expenses to the individual who incurs the expense on behalf of each covered **Dependent Child** if:

1. on the date of the **Covered Accident**, the covered **Dependent Child** was enrolled in an **Accredited Child Care Facility**, or enrolls in such facility within [ninety (90)] days from the date of loss; and
2. the **Dependent Child** is under age [thirteen (13)].

The Day Care Benefit will be equal to the lesser of:

1. the actual cost of the child care;
2. [three (3%)] of the Coverage Amount of the **Insured** who suffered the **Covered Loss**; or
3. [\$3,000].

If both an **Insured** and his or her covered **Spouse[/Domestic Partner]** suffer a simultaneous **Covered Loss** which is payable under the Accidental Death Benefit, the Day Care Benefit will be based on the **Insured's** Coverage Amount.

The Day Care Benefit will be paid annually for [four (4)] consecutive years if:

1. the covered **Dependent Child** is under age [thirteen (13)] at the time of each annual payment; and
2. proof is received by **Us** that verifies that the covered **Dependent Child** remains enrolled in an **Accredited Child Care Facility**.

The maximum amount payable under this benefit is [\$4,000].

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

This will be in or out. If in,

**[/Domestic Partner]** will be in or out.

[ninety (90)]. The range will be 30 - 365 days.

[thirteen (13)] The range will be 2 -18.

[three (3%)] The range will be 1% - 10%

[\$3,000] The range will be \$500 - \$30,000

**[/Domestic Partner]** will be in or out.

[four (4)]. The range will be 1 – 10.

[thirteen (13)] the range will be 2 – 18.

[\$4,000] the range will be \$500 - \$30,000.

[not] will be in or out.

HEARING AID OR PROSTHETIC APPLIANCE BENEFIT – U-BMC-349-A CW (09/11)

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit, **We** will pay an additional benefit provided:

1. the **Insured** is required to use a Hearing Aid or **Prosthetic Appliance**;
2. the **Covered Injury** that caused the payment of the Accidental Dismemberment [and Covered Loss of Use][and Plegia] Benefit is the same **Covered Injury** that requires the **Insured** to use the Hearing Aid or **Prosthetic Appliance**; and
3. the Hearing Aid or **Prosthetic Appliance** was required within [three hundred sixty-five (365)] days of the **Covered Injury**.

The maximum amount payable under all provisions of this benefit combined will be the lesser of [ten (10%)] of the Coverage Amount of the **Insured** that sustained the **Covered Injury** or [\$10,000].

**Related** means [the **Insured's Spouse[/Domestic Partner]** or other adult living with the **Insured**], sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

[and Covered Loss of Use] will be in or out.  
[and Plegia] will be in or out.

[and Covered Loss of Use] will be in or out.  
[and Plegia] will be in or out.

[three hundred sixty-five (365)] The range will be 90 - 730 days.

[ten (10%)]. The range will be 5% - 50%.

[\$10,000]. The range will be \$1,000 - \$50,000.

[the **Insured's Spouse[/Domestic Partner]** or other adult living with the **Insured**] will be in or out. If in [/**Domestic Partner**] will be in or out.

[not] will be in or out.

**EMERGENCY [TRANSPORTATION] [AND] [TREATMENT] [AND] HOSPITAL CASH BENEFIT  
U-BMC-353-A CW (09/11)**

<p><b>EMERGENCY [TRANSPORTATION] [AND] [TREATMENT] [AND] HOSPITAL CASH BENEFIT</b></p>	<p><b>[TRANSPORTATION] [AND] [TREATMENT] [AND]</b> will be in or out.</p>
<p>[EMERGENCY TRANSPORTATION BENEFIT If an <b>Insured</b> suffers a <b>Covered Injury</b> that requires <b>Emergency Treatment</b> within [12, 24, 48] hours of the date of the <b>Covered Accident</b> that caused the <b>Covered Injury</b> and it is determined that it is <b>Medically Necessary</b> that the <b>Insured</b> be transported to a <b>Hospital</b> or a <b>Satellite Emergency Center</b> by <b>Ambulance</b>, <b>We</b> will pay 100% of the Emergency Transportation Coverage Amount shown in the Schedule. Only one Emergency Transportation Benefit is payable for any one <b>Covered Accident</b> per <b>Insured</b>. [The maximum number of Emergency Transportation Benefits payable per calendar year per <b>Insured</b> regardless of the number of <b>Accidents</b> incurred, is shown in the Schedule.]]</p>	<p>This will be in or out. If in, [12, 24, 48] hours. One of these three choices will be inserted.</p>
<p>[EMERGENCY TREATMENT BENEFIT If an <b>Insured</b> suffers a <b>Covered Injury</b> that, within [24,48,72] hours of the date of the <b>Covered Accident</b> that caused the <b>Covered Injury</b>, requires him or her to receive <b>Medically Necessary Emergency Treatment</b> in a <b>Hospital</b> emergency room or a <b>Satellite Emergency Center</b>, <b>We</b> will pay 100% [of the applicable] Emergency Treatment Benefit Coverage Amount shown in the Schedule. Only one Emergency Treatment Benefit [, the largest,] is payable for any one <b>Covered Accident</b> per <b>Insured</b>. [The maximum number of Emergency Treatment Benefits payable per calendar year per <b>Insured</b> regardless of the number of <b>Covered Accidents</b> incurred, is shown in the Benefit Schedule.]]</p>	<p>This will be in or out.  This will be in or out. If in, [24, 48, 72] hours. One of these three choices will be inserted.</p>
<p>[If an <b>Insured</b> requires both Emergency Transportation and <b>Emergency Treatment</b> due to the same <b>Covered Accident</b>, only one Coverage Amount, the highest, will be paid.] [A maximum of [two (2)] Emergency Transportation Benefits or <b>Emergency Treatment</b> Benefits are payable per <b>Insured</b> per calendar year regardless of the number of <b>Covered Accidents</b> incurred in that same calendar year.]</p>	<p>[of the applicable] will be in or out. [, the largest,] will be in or out.</p>
<p><b>EMERGENCY HOSPITAL CASH</b> If the <b>Insured</b> is <b>Hospital Confined</b> due to <b>Covered Injury</b>, <b>We</b> will pay a daily allowance according to the actual days in <b>Hospital</b> up to the maximum benefit of [thirty (30)] days. [<b>We</b> will not pay any claim for the first three (3) calendar days of each emergency <b>Hospital Confinement</b> within the United States.]</p>	<p>This will be in or out.  This will be in or out. If in, [two (2)] the range will be 1 – 10.  [thirty (30)] The range will be 1 to 90. This will be in or out.</p>
<p>For the purposes of this rider only, the following additional definitions apply:</p>	<p>This will be in or out.</p>
<p>[<b>Ambulance</b> — means any publicly or privately owned surface, water or air vehicle, including a helicopter, that is</p>	

specifically designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded.

**Ambulance** does not include a surface, water or air vehicle that is owned and operated to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport.]

**Hospital Confinement (Hospital Confined)** means admission to a **Hospital** as an inpatient for at least [twenty-four (24)] consecutive hours by a **Physician** for a **Covered Injury**. A **Hospital** stay that does not result in charges to **Insured** 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 an [Emergency Treatment] [or] [Emergency Transportation] is:

1. essential for the diagnosis, treatment and care of the **Covered Injury**;
2. meets generally accepted standards of medical practice; [or]
3. is ordered by a **Physician** and performed under the **Physician's** care, supervision or order; or
4. [with regard to Emergency Transportation, is subsequently authorized by a **Physician** as appropriate due to the nature of the **Covered Injury**].

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

[twenty-four (24)] The range will be 12 to 96.

[Emergency Treatment] and [Emergency Transportation] will be in or out.  
[or] will be in or out.

[or] will be in or out.

This will be in or out.

[not] will be in or out.

**TRAUMATIC BRAIN INJURY BENEFIT - U-BMC-361-A AR (09/11)**

<p>If an <b>Insured</b> suffers a <b>Covered Injury</b> resulting in a <b>Traumatic Brain Injury</b> within [90] days of the date of the <b>Covered Accident</b> which:</p> <ol style="list-style-type: none"><li>1. requires that an <b>Insured</b> be <b>Hospitalized</b> for at least [seven (7)] days during the first [ninety (90)] days following the <b>Covered Accident</b>; and</li><li>2. continues for [nine (9)] consecutive months</li></ol> <p><b>We</b> will pay a <b>Traumatic Brain Injury</b> Benefit.</p> <p>This benefit will be paid after <b>We</b> receive Proof of Covered Loss in accordance with the Proof of Covered Loss section of the <b>Policy</b>.</p> <p>The <b>Traumatic Brain Injury</b> Benefit is equal to the Coverage Amount of the <b>Insured</b> that sustained the <b>Covered Injury</b>.</p> <p><b>[We</b> will not pay this benefit if a benefit is payable to an <b>Insured</b> for Loss of Life under the Accidental Death [and Accidental Dismemberment] Benefit].</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the <b>Policy</b>.</p>	<p>[90]. the range will be 60 – 365 days.</p> <p>[seven (7)]. The range will be 7 -14 days [ninety (90)]. The range will be 60 – 365 days. [nine (9)]. The range will be 6 -12 consecutive months.</p> <p>This will be in or out. If in, [and Accidental Dismemberment] will be in or out.</p> <p>[not] will be in or out.</p>
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HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT - U-BMC-371-A CW (09/11)

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Dismemberment [and Covered Loss of Use][and Plegia] benefit, **We** will pay an additional benefit for home alterations and vehicle modifications, provided:

1. the **Insured** is required to use a wheelchair to be ambulatory on a permanent basis; and
2. the **Covered Injury** that caused the payment of the Accidental Dismemberment [and Covered Loss of Use][and Plegia] benefit is the same **Covered Injury** that requires the **Insured** to use a wheelchair.

The maximum amount payable under all provisions of this benefit combined will be the lesser of [ten (10%)] of the Coverage Amount of the **Insured** that sustained the **Covered Injury** or [\$10,000].

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

[and Covered Loss of Use] will be in or out.  
[and Plegia] will be in or out.

[and Covered Loss of Use] will be in or out.  
[and Plegia] will be in or out.

[ten (10%)]. The range will be 1% - 50%.

[\$10,000]. The range will be \$1,000- \$50,000.

[not] will be in or out.

**NATURAL DISASTER BENEFIT U-BMC-372-A CW (09/11)**

<p>If an <b>Insured</b> suffers a <b>Covered Injury</b> resulting in a <b>Covered Loss</b>, which is payable under the Accidental Death [or Accidental Dismemberment] [and Covered Loss of Use] [and Plegia] Benefit, <b>We</b> will pay a benefit equal to the lesser of [ten (10%)] of the <b>Insured's</b> Coverage Amount or [\$10,000], provided the <b>Insured</b> suffers the <b>Covered Injury</b> as a direct result of a <b>Natural Disaster</b>.</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the <b>Policy</b>.</p>	<p>[or Accidental Dismemberment] [and Covered Loss of Use] [and Plegia] This will be in or out. [ten (10%)] The range will be 10% to 100%. [\$10,000] The range will be \$500 to \$50,000.</p> <p>[not] This will be in or out.</p>
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[OCCUPATIONAL] [OR] [VOLUNTEER ACTIVITY] HEPATITIS BENEFIT - U-BMC-373-A CW (09/11)

<p>[OCCUPATIONAL] [OR] [VOLUNTEER ACTIVITY] HEPATITIS BENEFIT</p>	<p>[OCCUPATIONAL] [OR] [VOLUNTEER ACTIVITY] These will be in or out.</p>
<p>If an <b>Insured</b> tests positive for <b>Hepatitis</b> within [three hundred sixty-five (365)] days of the date of the [Occupational Incident] [or] [Volunteer Activity], <b>We</b> will pay the Coverage Amount to the <b>Insured</b> as shown on the Schedule. The benefit is payable if, within 72 hours of the [Occupational Incident] [or] [Voluntary Activity] the <b>Insured</b></p>	<p>[three hundred sixty-five (365)] The range will be 30 – 365.</p>
<ol style="list-style-type: none"> <li>1. reports the [Occupational Incident] [or] [Volunteer Activity] to <b>Us</b> in writing; and</li> <li>2. undergoes a Food and Drug Administration (FDA) approved preliminary screening test for <b>Hepatitis</b> which indicates negativity with respect to the presence of any antibodies or antigens to such disease.</li> </ol>	<p>[Occupational Incident] [or] [Volunteer Activity] these will be in or out.</p>
<p>The benefit is payable monthly, starting on the last day of the month which immediately follows the month the <b>Insured</b> tests positive for Hepatitis, for [one hundred twenty-seven (127)] consecutive months or until: . . .</p>	<p>[Occupational Incident] [or] [Volunteer Activity] these will be in or out.</p>
<p>If the <b>Insured</b> tests positive for <b>Hepatitis</b> as a result of the same [Occupational Incident] [or] [Volunteer Activity], only one Coverage Amount, the largest, will be paid. <b>We</b> will not pay for any expenses incurred for testing.</p>	<p>[Occupational Incident] [or] [Volunteer Activity] these will be in or out. [and the <b>Policyholder</b>] will be in or out.</p>
<p>For purposes of this rider only, the following additional definitions apply:</p>	<p>[one hundred twenty-seven (127)] The range will be 1 - 180</p>
<p><b>Hepatitis</b> means inflammation of the liver caused by a virus or a toxin. <b>Hepatitis</b> includes Hepatitis [A], B, C, D and E.</p>	<p>[Occupational Incident] [or] [Volunteer Activity] these will be in or out.</p>
<p>[Occupational Incident(s)], means a <b>Covered Accident</b> resulting in exposure to <b>Hepatitis</b> which occurs while the <b>Insured</b> is performing occupational services. The exposure must be either:</p> <ol style="list-style-type: none"> <li>1. cutaneous through abraded skin;</li> <li>2. percutaneous; or</li> <li>3. mucocutaneous.]</li> </ol>	<p>[A] will be in or out.</p>
<p>[Volunteer Activity (Volunteer Activities) means a <b>Covered Accident</b> resulting in exposure to <b>Hepatitis</b> which occurs while the <b>Insured</b> is performing services as a volunteer. The exposure must be either:</p> <ol style="list-style-type: none"> <li>1. cutaneous through abraded skin;</li> <li>2. percutaneous; or</li> <li>3. mucocutaneous.]</li> </ol>	<p>This will be in or out.</p>
<p>This rider only provides benefits for [Occupational Incidents] [or] [Volunteer Activity] as defined above.</p>	<p>This will be in or out.</p>
	<p>[Occupational Incident] [or] [Volunteer Activity] these will be in or out.</p>

This rider is [not] subject to the limitations in Section V  
General Limitations of the **Policy**.

[not] will be in or out.

**RECUPERATION BENEFIT U-BMC-374-A CW (09/11)**

<p>If an <b>Insured</b> suffers a <b>Covered Injury</b> resulting in a <b>Covered Loss</b> and the <b>Insured</b> is eligible to receive benefits payable under the [In-Hospital Indemnity Benefit] of the <b>Policy</b>, <b>We</b> will pay an additional Recuperation Benefit.</p> <p>The Recuperation Benefit is equal to the Coverage Amount shown on the Schedule and will be paid for the same [period of time as the] [number of days as was actually paid for the] [In-Hospital Indemnity Benefit].</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the <b>Policy</b>.</p>	<p>[In-Hospital Indemnity Benefit] This is to be replaced with other benefits that include a <b>Hospital Confinement</b>, as defined within those associated benefit riders.</p> <p>[period of time as the] [number of days as was actually paid for the] one of these will be included and the range will vary from \$25 to \$1,000 per day per <b>Insured</b> consistent with the benefit to which is inserted.</p> <p>[In-Hospital Indemnity Benefit] This is to be replaced with other benefits that include a <b>Hospital Confinement</b>, as defined within those associated benefit riders.</p> <p>[not] will be in or out.</p>
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**STUDENT [TUITION] [AND] [EXPENSE] REIMBURSEMENT BENEFIT U-BMC-375-A CW (09/11)**

<p><b>STUDENT [TUITION] [AND] [EXPENSE] REIMBURSEMENT BENEFIT</b></p>	<p>[TUITION] [AND] [EXPENSE] will be in or out.</p>
<p>[Student Loan Reimbursement If [a <b>Covered Person</b>][an <b>Insured</b>] that is a <b>Tuition Payor</b> and suffers a <b>Covered Loss</b> that is payable under the [Accidental Death [and Accidental Dismemberment]][Critical Illness] Benefit, <b>We</b> will pay the <b>Covered Person's</b> outstanding loan balance incurred for <b>Student Tuition</b> as of date of the <b>Covered Loss</b> and owed to a financial institution or federal government for <b>Academic Studies</b>. The most <b>We</b> will pay is up to the Coverage Amount shown on the Schedule.]</p>	<p>This will be in or out. If in:  [Accidental Death [and Accidental Dismemberment]] will be in or out. If in, [and Accidental Dismemberment] will be in or out. [Critical Illness] will be in or out.  The Coverage Amount will range from \$100 per <b>Covered Person</b> per outstanding loan balance to \$100,000 for all <b>Covered Person's</b> outstanding loan balances in the aggregate.</p>
<p>[Tuition Reimbursement If [a <b>Covered Person</b>][an <b>Insured</b>] enrolled in <b>Academic Studies</b> suffers a <b>Covered Loss</b> that is payable under the [Accidental Death [and Accidental Dismemberment]][Critical Illness] Benefit and which prevents the [Covered Person][Insured] from continuing to participate in it's <b>Academic Studies</b>, <b>We</b> will pay <b>Tuition Expense(s)</b> up to the Coverage Amount shown on the Schedule.]</p>	<p>This will be in or out. If in:  [Accidental Death [and Accidental Dismemberment]] will be in or out. If in, [and Accidental Dismemberment] will be in or out. [Critical Illness] will be in or out.  The <b>Tuition Expense</b> amount will range from \$100 per <b>Covered Person</b> to \$500,000 for all <b>Covered Persons</b> in the aggregate.</p>
<p>[Student Tuition and Tuition Expenses If [a <b>Covered Person</b>][an <b>Insured</b>] that is a <b>Tuition Payor</b> suffers a <b>Covered Loss</b> that is payable under the [Accidental Death [and Accidental Dismemberment]][Critical Illness] Benefit and there is an obligation to pay <b>Student Tuition</b> to the <b>Policyholder</b> on behalf of the <b>Covered Person</b>, <b>We</b> will pay an annual benefit up to the maximum number of payments as shown on the Schedule. The Coverage Amount will increase annually by the lesser of the actual <b>Student Tuition</b> and <b>Tuition Expense</b>, or [ten (10%)].]</p>	<p>This will be in or out. If in:  [Accidental Death [and Accidental Dismemberment]] will be in or out. If in, [and Accidental Dismemberment] will be in or out. [Critical Illness] will be in or out.  The annual benefit will range from \$100 to \$50,000 per <b>Covered Person</b> and up to \$200,000 in the aggregate for all <b>Covered Persons</b>. The maximum number of payments will range from 1 to 16 per <b>Covered Person</b>. [ten (10%)] the Coverage Amount increase will vary from 0 to 100%.</p>
<p>[Student Expenses If [a <b>Covered Person</b>][an <b>Insured</b>] that is a <b>Tuition Payor</b> and suffers a <b>Covered Loss</b> that is payable under the [Accidental Death [and Accidental Dismemberment]][Critical Illness] Benefit and prevents the <b>Tuition Payor</b> from continuing to pay the <b>Student Expenses</b> incurred by [Covered Person][an <b>Insured</b>] for <b>Academic Studies</b>, <b>We</b> will pay an annual benefit up to the maximum number of payments as shown on the Schedule. The Coverage Amount will increase annually by the lesser of the actual <b>Student Expenses</b> or [ten (10%)].]</p>	<p>This will be in or out. If in:  [Accidental Death [and Accidental Dismemberment]] will be in or out. If in, [and Accidental Dismemberment] will be in or out. [Critical Illness] will be in or out.  The annual benefit will range from \$100 to \$50,000 per <b>Covered Person</b> and up to \$200,000 in the aggregate for all <b>Covered Persons</b>. The maximum number of payments</p>

For the purposes of this rider only, the following additional conditions apply :

Payment Of Claims. Unless otherwise requested by the **Insured**, the [Accidental Death [and Accidental Dismemberment]] [Critical Illness] Benefit will be paid directly to the [**Covered Person**] [or] [beneficiary] [or] **Policyholder**] up to the total amount of actual [**Tuition Expense**] [and] [**Student Expenses**] due from the **Tuition Payor**. Any payment made in good faith will release **Us** from any liability to the extent of the payment.

For the purposes of this rider only, the following additional definitions apply:

**Academic Studies** means the full-time attendance at an educational institution or school for the purpose of advancing education and for which the **Tuition Payor** incurred **Student Tuition** [and room and board (if supplied by the university, college or trade school)] to attend.

[**Covered Person** means any person who has insurance under the terms of this **Policy**. It includes the **Insured** [,and his or her **Spouse/Domestic Partner**] and/or **Dependent Child(ren)** if a **Plan** covering the **Spouse** [/**Domestic Partner**] and/or **Dependent Child(ren)** is selected. **Covered Person** also includes the **Spouse/Domestic Partner**] and/or **Dependent Child(ren)** designated by the **Insured** as enrolled in **Academic Studies** regardless of the **Plan** chosen by the **Insured**.]

[**Dependent** means the **Insured's Spouse** [/**Domestic Partner**] and **Dependent Child(ren)**, as defined in this section. [A **Dependent** will only be a covered **Dependent** if a **Plan** covering **Dependents** is selected and all other conditions of coverage are satisfied.]]

[**Dependent Child(ren)** means the **Insured's** unmarried child(ren) and those of the **Insured's Spouse/Domestic Partner**] who rely on the **Insured** for support, and are either: 1) less than [nineteen (19)] years of age; 2) less than [twenty-five(25)] years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or her termination of coverage became incapable of self-sustaining employment by reason of mental or physical handicap.]

[For the purposes of this benefit only, the following additional exclusions apply.

Benefit does not apply to:

1. [Expenses previously reimbursed to the **Tuition Payor** or **Covered Person** through any

will range from 1 to 16 per **Covered Person**. [ten (10%)] the Coverage Amount increase will vary from 0 to 100%.

[Accidental Death [and Accidental Dismemberment]] will be in or out. If in, [and Accidental Dismemberment] will be in or out.  
[Critical Illness] will be in or out.  
[or] [beneficiary] [or] **Policyholder**] each will be in or out.  
[**Tuition Expense**] [and] [**Student Expenses**] each will be in or out.

This will be in or out.

This will be in or out. If in,

This will be in or out. If in, [/**Domestic Partner**] will be in or out.  
[/**Domestic Partner**] will be in or out.

[/**Domestic Partner**] will be in or out.

This will be in or out. If in, [/**Domestic Partner**] will be in or out.  
This will be in or out.

This will be in or out. If in, [/**Domestic Partner**] will be in or out.

[nineteen (19)] the range will be 1 to 26.  
[twenty-five(25)] the range will be 1 to 50.

These will be in or out. If in,

Each Exclusion 1 – 4 will be in or out.

employment tuition reimbursement program;]

2. [Academic Scholarships provided to the **Covered Person**.]
3. [Athletic Scholarships provided to the **Covered Person**.]
4. [Student loans made by the **Policyholder** to or on behalf of the **Tuition Payor** or the **Covered Person**. This does not include student loans made by a third party and facilitated by the **Policyholder**.]

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

[not] will be in or out.

**ACCELERATED PAYMENT BENEFIT - U-BMC-376-A CW (09/11)**

In the event that an **Insured** is **Terminally Injured**, the **Insured** may be eligible to receive an Accelerated Payment Benefit (Accelerated Benefit). **We** will pay the applicable Accelerated Benefit up to the Coverage Amount shown on the Schedule, provided the **Terminally Injured Insured**:

1. is covered under the **Policy**;
2. is under age [60-70]; and
3. gives Proof of Loss to **Us** of such **Terminal Injury**.

The **Insured** may request a minimum Accelerated Payment Benefit Coverage Amount of [\$3,000, and a maximum of \$100,000]. However, in no event will the Accelerated Payment Benefit exceed [thirty (30%)] of the **Terminally Injured Insured's** Coverage Amount of Accidental Death Benefit. [This option may be exercised only once for each **Insured**.] The Accelerated Benefit payment will be made to the **Insured** now instead of the **Insured's** beneficiary upon death.

[For example, if the **Insured** is covered for an Accidental Death Benefit for \$100,000 and is **Terminally Injured**, the **Insured** can request any portion of the amount of Accidental Death Benefit Coverage Amount from \$3,000 to \$30,000 to be paid now instead of to the **Insured's** beneficiary upon death. However, if the **Insured** decides to request only \$3,000 now, the **Insured** cannot request the additional \$27,000 in the future]. Any payments received under this rider may be taxable. The **Insured** should consult a personal tax advisor for further information.

For purposes of this rider only, the following additional definitions apply:

**Disabled** means that due to the **Terminal Injury** the **Insured**:

1. is unable to perform the material and substantial duties of any occupation to which the **Insured** is suited by education, training, and experience; [or
2. with respect to a **Spouse[/Domestic Partner]** who is unemployed, his or her ability to engage in the normal and customary activities of a person of like age and gender in good health.]

**Terminal Injury or Terminally Injured** means the **Covered Injury** that resulted in the **Insured** having a life expectancy of [nine (9)] months or less.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

[60 - 70] either 60 or 70 will be inserted.

[\$3,000 and a maximum of \$100,000]. The range will be \$500 and a maximum amount of \$500,000. [thirty (30%)] the range will be 10% - 100%. This will be in or out.

This will be in or out. If in, the ranges will be consistent with that above.

This will be in or out. If in, **[/Domestic Partner]** This will be in or out.

[nine (9)] The range will be 6 - 12 months.

[not] will be in or out.

**ACCIDENT MEDICAL EXPENSE - INDEMNITY BENEFIT - U-BMC-377-A CW (09/11)**

<p>[Emergency Room Treatment  <b>We</b> will pay [\$500] once per [forty-eight (48)] hour period and once per <b>Covered Accident</b>, per <b>Insured</b> when that <b>Insured</b> receives emergency room treatment for <b>Injuries</b> sustained in a <b>Covered Accident</b>. This benefit is for treatment by a <b>Physician</b> or treatment received in a <b>Hospital</b> emergency room. Treatment must be received within [forty-eight (48)] hours of the <b>Accident</b> for benefits to be payable.]</p>	<p>This will be in or out.                  If in, [\$500] the range will be \$25 - \$5,000.                  [forty-eight (48)] the range will be 12-96.</p> <p>[forty-eight (48)] the range will be 12 – 96</p>
<p>[X-Rays Related to an <b>Accident</b>  <b>We</b> will pay [\$500] once per <b>Covered Accident</b>, per <b>Insured</b> when an <b>Insured</b> requires an X-ray while receiving emergency room treatment in a <b>Hospital</b> for <b>Injuries</b> sustained in a <b>Covered Accident</b>. This benefit is not for X-rays received in a <b>Physician's</b> office. [The X-Ray Benefit is not for exams listed in the Diagnostic Testing &amp; Exams Benefit.]]</p>	<p>This will be in or out. If in,                  [\$500] The range will be \$25 - \$1,000</p> <p>This will be in or out.</p>
<p>[Emergency Room Follow Up Treatment  <b>We</b> will pay [\$500] for one treatment per day, up to a maximum of [three (3)] treatments per <b>Covered Accident</b> for an <b>Insured</b> when that <b>Insured</b> receives emergency room treatment for <b>Injuries</b> sustained in a <b>Covered Accident</b> and later requires additional treatment in addition to the original emergency room treatment administered in the first [forty-eight (48)] hours following the <b>Covered Accident</b>. The emergency room follow up treatment must begin within [thirty (30)] days of the <b>Covered Accident</b> or discharge from the <b>Hospital</b>, the <b>Hospital Confinement</b> which must be related to the same <b>Covered Accident</b> for which the subsequent treatment is being sought. Treatments must be furnished by a <b>Physician</b> in a <b>Physician's</b> office or in a <b>Hospital</b> on an outpatient basis. This benefit is not payable for days wherein additional emergency room treatment benefits are paid.]</p>	<p>This will be in or out. If in,                  [\$500] the range will be \$25 - \$1,000                  [three (3)] the range will be 2 - 6</p> <p>[forty-eight (48)] the range will be 12 – 96</p> <p>[thirty (30)] the range will be 10 - 90</p>
<p>[Accident Hospitalization  <b>We</b> will pay [\$500] once per period of <b>Hospital Confinement</b> or [\$500] once when an <b>Insured</b> is admitted directly to an <b>Intensive Care Unit</b> [two (2)] time(s) per calendar year per <b>Insured</b> when that <b>Insured</b> is admitted for a <b>Hospital Confinement</b> of at least [eighteen (18)] hours for treatment of <b>Injuries</b> sustained in a <b>Covered Accident</b> or if an <b>Insured</b> is admitted directly to an <b>Intensive Care Unit</b> of a <b>Hospital</b> for treatment of <b>Injuries</b> sustained in a <b>Covered Accident</b>. <b>Hospital Confinements</b> must start within [sixty (60)] days of the <b>Covered Accident</b>.]</p>	<p>This will be in or out. If in,                  [\$500] the range will be \$500 - \$10,000                  [\$500] the range will be \$500 - \$10,000                  [two (2)] times (s) the range will be 1 -10</p> <p>[eighteen (18)] the range will be 12 – 24</p> <p>[sixty (60)] the range will be 10 – 90</p>
<p>[Specific Coverage Amount Accidental Injuries  <b>We</b> will pay [\$5,000] for the following <b>Covered Injuries</b>:                  [1. Dislocation Benefit</p>	<p>This will be in or out. If in,                  [\$5,000] the range will be \$25 - \$10,000</p> <p>This will be in or out. If in,</p>

**Dislocation** (reduced under general anesthesia): **We** will pay for no more than [two (2)] **Dislocations** per **Covered Accident** per **Insured**.

Benefits are payable for each **Dislocation** for each joint but for only the first **Dislocation** of a joint.

Benefit:

Joint Area	Open Reduction	Closed Reduction
A. - J.	[\$2,500]	[\$500]

If a **Dislocation** is reduced with local anesthesia, or no anesthesia by a **Physician** or a Physician's Assistant, **We** will pay [fifty (50%)] percent of the amount shown for the closed **Reduction Dislocation**.]

[2. Burn Benefit

For burns arising out of a **Covered Accident** and treated by a **Physician** within [forty-eight (48)] hours after that **Covered Accident**, **We** will pay the following:

Benefit:

Body Surface Area	2 <sup>nd</sup> Degree	3 <sup>rd</sup> degree
A. Less than 50 sq. cm.	[2,500]	[\$5,000]
B. > than 100 but < 150 sq. cm	[2,500]	[\$5,000]
C. > than 150 but < 200 sq. cm	[2,500]	[\$5,000]
D. > than 200 but < 250 sq. cm	[2,500]	[\$5,000]
E. > than 250 but < 300 sq. cm	[2,500]	[\$5,000]
F. > than 300 sq cm	[2,500]	[\$5,000]

[3. Skin Grafts

If an **Insured** receives up to [five (5)] skin graft(s) for a burn from a **Covered Accident**, **We** will pay a total of [seventy-five (75%)] of the Burns Benefit Coverage Amount **We** paid for the burn involved in addition to the amount paid for the Burn Benefit.]

[4. Eye Injuries

If an **Insured** sustains an **Injury** to an eye as a result of a **Covered Accident**, **We** will pay the following:  
 a. Surgical repair [\$1,000]  
 b. Removal of foreign body by a **Physician** [\$250].]

[5. Lacerations

If the **Insured** sustains a laceration as a result of a **Covered Accident**, provided the laceration is repaired within [forty-eight (48)] hours after the **Covered Accident** and repaired under the attendance of a **Physician**, **We** will pay the following:

Benefit:

Laceration	Coverage Amount
A. Laceration(s) not requiring . . .	[\$500]
B. Laceration(s) less than 5 cm. . . .	[\$500]
C. Lacerations at least 5 cm. . . .	[\$500]
D. Lacerations over 15 cm . . . .	[\$500]

[two (2)] the range will be 1 – 10

If in,

Joint Area	Open Reduction	Closed Reduction
A. – J.	[\$25 - 5,000]	[\$25 -1,500]

[fifty (50%)] the range will be 25 – 100

This will be in or out. If in,

[forty-eight (48)] the range will be 12 – 96

If in, the ranges will be

Body Surface Area	2 <sup>nd</sup> Degree	3 <sup>rd</sup> degree
A. Less than 50 sq. cm.	[\$25-5,000]	[\$100-10,000]
B. > than 100 but < 150 sq. cm	[\$25-5,000]	[\$100-10,000]
C. > than 150 but < 200 sq. cm	[\$25-5,000]	[\$100-10,000]
D. > than 200 but < 250 sq. cm	[\$25-5,000]	[\$100-10,000]
E. > than 250 but < 300 sq. cm	[\$25-5,000]	[\$100-10,000]
F. > than 300 sq cm	[\$25-5,000]	[\$100-10,000]

This will be in or out. If in,

[five (5)] the range will be 1 -10

[seventy-five (75%)] the range will be 10% - 150%

This will be in or out. If in,

[\$1,000] the range will be \$25 – \$2,500

[\$250] the range will be \$25 - \$500

This will be in or out. If in,

[forty-eight (48)] the range will be 12-96

If in, the ranges will be

Benefit:

Laceration	Coverage Amount
A. Laceration(s) not requiring . . .	[\$25 - 1,000]
B. Laceration(s) less than 5 cm. . . .	[\$25 - 1,500]
C. Lacerations at least 5 cm. . . .	[\$25 - 2,500]
D. Lacerations over 15 cm . . . .	[\$25 - 5,000]

[6. **Fractures**

**We** will pay for no more than [five (5)] **Fractures** per **Covered Accident**, per **Insured**. In the event of multiple fractures (more than [three (3)]) sustained by the same **Insured**, **We** will pay for the largest **Fracture** amounts. However, **We** will pay [fifty (50%)] percent of the Coverage Amount shown for the closed **Reduction** for **Chip Fractures** and other **Fractures** not reduced by Open or Closed **Reduction**.

This will be in or out. If in, [five (5)] the range will be 1 -10

[three (3)] the range will be 2 – 10

[fifty (50%)] the range will be 10 -100

If in, the ranges will be as follows:

Fracture Area	Open Reduction	Closed Reduction
A. – Q.	[\$100- 25,000]	[\$100 -15,000]
R. Finger	[\$100 – 5,000]	[\$100 – 2,500]
S. Coccyx	[\$100 – 25,000]	[\$100 – 15,000]
T. Toe	[\$100 – 5,000]	[\$100 – 2,500]
U Vertebral	[\$100 – 25,000]	[\$100 – 15,000]
V. Skull		
(i) Depressed	[\$100-25,000]	[\$100-15,000]
(ii) Simple	[\$100-25,000]	[\$100 -15,000]

Benefit:

Fracture Area	Open Reduction	Closed Reduction
A. – Q.	[\$15,000]	[\$7,500]
R. Finger	[\$2,500]	[\$1,000]
S. Coccyx	[\$10,000]	[\$7,500]
T. Toe	[\$2,500]	[\$1,000]
U. Vertebral	[\$10,000]	[\$7,500]
V. Skull		
(i) Depressed	[\$10,000]	[\$7,500]
(ii) Simple	[\$10,000]	[\$7,500]

[7. Concussion:

If the **Insured** sustains a concussion as a result of a **Covered Accident**, **We** will pay [\$1,000] for each concussion for each **Insured**.]

This will be in or out. If in,

[\$1,000] the range will be \$50 – \$1,500

[8. Emergency Dental Procedure:

If the **Insured** sustains a **Covered Injury** as a result of a **Covered Accident** requiring emergency dental work, **We** will pay the following benefits:

- a. Broken tooth repaired with crown [\$750]
- b. Broken tooth resulting in extraction [\$750]

This will be in or out. If in,

- a. [\$750] the range will be \$75 – \$1,500
- b. [\$750] the range will be \$25 – \$1,500]

Emergency dental work does not include false teeth such as dentures, bridges, veneers, partials, crowns, or implants. **We** will pay for no more than [two (2)] Emergency Dental Procedure benefit(s) per **Covered Accident**, per **Insured**.]

[two (2)] the range will be 1 – 5

[9. Specified Surgical Procedures Arising from a Covered Accident:

If the **Insured** sustains a **Covered Injury** as a result of a **Covered Accident** and one of the specified surgical procedures is required, such surgical procedure must be performed within [one (1)] year(s) of the **Covered Accident**. [Two or more surgical procedures performed through the same incision will be considered one surgical procedure.] In the event of multiple procedures, **We** will pay for the most expensive procedure.

This will be in or out. If in,

[one (1)] the range will be 1 - 3

This will be in or out.

Benefit:

Surgical Procedure	Coverage Amount
A. Arthroscopy without surgical repair	[\$5,000]
B. Open abdominal	[\$5,000]
C. Cranial	[\$5,000]
D. Hernia	[\$5,000]

If in, the ranges will be:

- [\$5,000] the range will be \$25 - \$10,000
- [\$5,000] the range will be \$25 - \$10,000
- [\$5,000] the range will be \$25 - \$10,000
- [\$5,000] the range will be \$25 - \$10,000

<p>E. Thoracic surgery [5,000]  F. Repair of: [5,000]  i. Tendons and/or ligaments  ii. Torn rotator cuffs  iii. Ruptured discs  iv. Torn knee cartilages ]</p>	<p>[5,000] the range will be \$25 - \$10,000  [5,000] the range will be \$25 - \$10,000</p>
<p>[10. Non-Specified Surgical Procedures Arising from a <b>Covered Accident</b>:  If the <b>Insured</b> sustains a <b>Covered Injury</b> as a result of a <b>Covered Accident</b> and a non- specified surgical procedure is required, such surgical procedure must be performed within [one (1)] year of <b>Covered Accident</b>. [Two or more surgical procedures performed through the same incision will be considered one surgical procedure.] In the event of multiple procedures, <b>We</b> will pay for the most expensive procedure. <b>We</b> will pay for the following:</p> <p>a. Miscellaneous surgery with general anesthesia [2,500]  b. Other miscellaneous surgery with conscious sedation [2,500]]</p>	<p>This will be in or out. If in,    [one (1)] the range will be 1-3  This will be in or out.    a. [2,500] the range will be \$25 – \$2,500  b. [2,500] the range will be \$25 – \$2,500</p>
<p>[Diagnostic Testing &amp; Exams Benefit  <b>We</b> will pay [2,500] [five (5)] time(s) per calendar year, per <b>Insured</b> when a <b>Insured</b> requires one of the following exams for <b>Injuries</b> sustained in <b>Covered Accident</b> and a charge is incurred: computerized tomography (CT scan), computerized axial tomography (CAT), magnetic resonance imaging (MRI), or electroencephalography (EEG). These exams must be performed in a Hospital or a Physician’s office. [Exams listed in the Diagnostic Testing &amp; Exams Benefit are not covered under the X-Ray Benefit.]]</p>	<p>This will be in or out. If in,  [2,500] the range will be \$25 – \$5,000  [five (5)] the range will be 1 – 10 time(s)    This will be in or out.</p>
<p>[Pain Management  <b>We</b> will pay [2,500] no more than [five (5)] time(s) per <b>Covered Accident</b>, per <b>Insured</b> when the <b>Insured</b> is prescribed, receives, and incurs a charge for an epidural or other similar treatment administered for pain management in a <b>Hospital</b> or a <b>Physician’s</b> office for <b>Injuries</b> sustained in a <b>Covered Accident</b>. This benefit is not for an epidural or other similar treatment administered during a surgical procedure [or for pain management associated with pregnancy].]</p>	<p>This will be in or out. If in,  [2,500] the range will be \$25 – \$5,000  [five (5)] the range will be 1 – 10 time (s)    This will be in or out.</p>
<p>[Physical Therapy and Rehabilitation  <b>We</b> will pay [250] per treatment for [two (2)] treatment(s) per day, up to a maximum of [five (5)] treatment(s) per <b>Covered Accident</b>, per <b>Insured</b> when the <b>Insured</b> receives emergency treatment for <b>Injuries</b> sustained in a <b>Covered Accident</b> and later a <b>Physician</b> advises the <b>Insured</b> to seek treatment from a licensed <b>Physical Therapist</b>. Physical therapy must be for <b>Injuries</b> sustained in a <b>Covered Accident</b> and must start within [thirty (30)] days of the <b>Covered Accident</b> or discharge</p>	<p>This will be in or out. If in,  [250] the range will be \$25 - \$500  [two (2)] either 1 or 2 will be inserted.  [five (5)] the range will be 1 – 10    [thirty (30)] the range will be 10 – 90</p>

from the **Hospital**. The treatment must take place within [six (6)] month(s) after the **Covered Accident**. [The Physical Therapy and Rehabilitation Benefit are not payable on the same day that the Emergency Room Follow Up Treatment Benefit is payable.]]

[Durable Medical Equipment and Prosthetic Appliance  
**We** will pay [\$5,000] once per **Covered Accident**, per **Insured** when an **Insured** receives **Durable Medical Equipment**, prescribed by a **Physician**, as an aid in personal locomotion for **Injuries** sustained in a **Covered Accident**. Benefits are for the following types of appliances: a wheelchair, a leg brace, a back brace, a walker, and/or a pair of crutches. **We** will pay [\$5,000] once per **Covered Accident** per **Insured** when an **Insured** requires use of a **Prosthetic Appliance** as a result of **Injuries** sustained in a **Covered Accident**. This benefit is not intended to provide a benefit for the repair or replacement of **Prosthetic Appliance** already prescribed for the **Insured**, hearing aids, wigs, or dental aids, including false teeth.]

[Blood, Plasma, and or Platelets  
**We** will pay [\$2,500] once per **Covered Accident** per **Insured** when that **Insured** receives blood, plasma, and/or platelets for the treatment of **Injuries** sustained in a **Covered Accident**. This benefit is not intended to pay for immunoglobulins or other similar treatments.]

[Ambulance  
**We** will pay [\$500] when an **Insured** requires transportation by **Ambulance** and [\$5,000] when that **Insured** requires air ambulance transportation to a **Hospital** for **Injuries** sustained in a **Covered Accident**. Air Ambulance services must take place within [forty-eight (48)] hours of the **Covered Accident**. **Ambulance** transportation must be within [forty-eight (48)] hours of the **Covered Accident**. A licensed professional ambulance company must provide the ambulance service. A licensed professional air ambulance company must provide the air ambulance service.]

[Transportation  
**We** will pay [\$25] per round trip, up to three round trips per calendar year, per **Insured** per round trip to a **Hospital** when an **Insured** requires **Hospitalization** or **Hospital Confinement** for medical treatment due to an **Injury** sustained in a **Covered Accident**. This benefit may also be used; if a covered **Dependent Child** requires **Hospitalization** or **Hospital Confinement** for medical treatment due to an **Injury** sustained in a **Covered Accident**, if commercial travel is necessary and such **Dependent Child** is accompanied by a person **Related** to the **Insured**. This benefit is not for transportation to any **Hospital** located within a [fifty (50)]-mile radius from the site of the **Accident** or the residence of the **Insured**. The local attending **Physician** must

[six (6)] the range will be 1 – 12  
This will be in or out.

This will be in or out. If in,  
[\$5,000] the range will be \$25 – \$10,000

[\$5,000] the range will be \$25 – \$10,000

This will be in or out. If in,  
[\$2,500] the range will be \$25 – \$5,000

This will be in or out. If in,  
[\$500] the range will be \$25 – \$1,000  
[\$5,000] the range will be \$25 – \$10,000

[forty-eight (48)] the range will be 12 – 96

[forty-eight (48)] the range will be 12 – 96

This will be in or out. If in,  
[\$25] the range will be \$25 - \$1,000

[fifty (50)] the range will be 5 - 100

prescribe the treatment requiring **Hospitalization** or **Hospital Confinement**, and the treatment must not be available locally. This benefit is not for transportation by ambulance or air ambulance to the **Hospital**.]

[Accommodations During Hospital Confinement  
**We** will pay [\$50] per night, limited to one motel/hotel room per night, up to [five (5)] days per **Covered Accident** for one motel/hotel room for a member of the immediate family who accompanies an **Insured** who is admitted for **Hospitalization** or **Hospital Confinement** for the treatment of **Injuries** sustained in a **Covered Accident**. This benefit is only during the same period of time the injured **Insured** is confined to the **Hospital**. The **Hospital** and motel or hotel must be more than [fifty (50)] miles from the residence of the **Insured**.]

For purposes of this rider only, the following additional definitions apply:

**Ambulance** means any publicly or privately owned surface, water or air vehicle, including a helicopter, that is specifically designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded. Ambulance does not include a surface, water or air vehicle that is owned and operated to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport.]

**Durable Medical Equipment** means equipment or apparatus of a type that is designed primarily for use, and used primarily, to assist persons suffering from illnesses or injuries that restrict their normal mobility and function and includes equipments such as a wheelchair or a hospital bed. It does not include items commonly used by persons that are not injured, even if the items can be used in the treatment of injury or can be used for rehabilitation or improvement of health such as a stationary bicycle or a spa.]

**Dislocation** means a completely separated joint due to an **Injury**. The **Dislocation** must be diagnosed by a **Physician** [within seventy-two (72) hours] after the date of the **Injury** and require correction by a **Physician**.

**Fracture** means a break in a bone due to an **Injury** and that can be seen by X-ray or other similar diagnostic exam. The **Fracture** must be diagnosed by a **Physician** [within fourteen (14) days after the date of the **Covered Injury**] and require correction by a **Physician**.

**Related** means [the **Insured's Spouse[/Domestic Partner]** or other adult living with the **Insured**], sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar

This will be in or out. If in, [\$50] the range will be \$25 – \$1,000 [five (5)] the range will be 5 - 30

[fifty (50)] the range will be 5 – 100

This will be in or out.

This will be in or out.

[within seventy-two (72) hours] will be in or out.

[within fourteen (14)days after the date of the **Covered Injury**] will be in or out.

[the **Insured's Spouse[/Domestic Partner]** or other adult living with the **Insured**] will be in or out. If in **[/Domestic Partner]** will be in or out.

relationship in law.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

[not] will be in or out.

**COMPLICATIONS OF PREGNANCY BENEFIT- U-BMC-378-A AR (09/11)**

If an **Insured** suffers **Covered Complications of Pregnancy**, [other than a **Non-elective Cesarean Section**,] resulting from a **Covered Accident**, We will pay the [coinsurance percentage of the] [**Usual and Customary**] expenses for **Medically Necessary** Covered Medical Service(s) incurred up to the Coverage Amount as shown on the Schedule. [The Coverage Amount is the amount payable per calendar year for all **Covered Complications of Pregnancy** payable under the **Policy**.] This benefit is payable only for such **Covered Charges** incurred [after the **Deductible**, as shown on the Schedule, has been met and] on or after the date the **Insured** suffers the **Covered Complications**. [**Complications of Pregnancy** Benefits are in excess of all other valid and collectible Insurance.]

[If the **Covered Complication of Pregnancy** is a **Medically Necessary Non-elective Cesarean Section**, after the applicable **Deductible** has been met and on or after the date the **Non-elective Cesarean Section** is performed, benefits are payable on the same basis as any other **Covered Complication** for **Covered Charges** incurred, up to the Coverage Amount shown in the Benefit Schedule.]

[Additional Benefit  
If the **Insured's** coverage terminates under this benefit solely due to the birth of a child, an Additional Benefit will be provided for [six (6)] [weeks][months] from the date of termination for [**Covered Complications**] [and] [post-partum depression] resulting solely from that **Covered Accident**. This benefit is payable only for such **Covered Charges** incurred [after the applicable **Deductible**, as shown on the Schedule, has been met and] on or after the date the **Insured** suffers the **Covered Complications**, subject to the Additional Benefit Coverage Amount shown on the Schedule. [The overall Coverage Amount for **Complications of Pregnancy** payable per calendar year will be reduced by the amount paid under this Additional Benefit.] Benefits provided under this rider are subject to all other terms and limitations of the **Policy**.]

For purposes of this rider only, the following additional definitions apply:

**Covered Complications of Pregnancy (Covered Complications)** means any of the following conditions requiring [treatment by a **Physician**] [**Hospital Confinement**] [when the pregnancy is not terminated] whose diagnoses...

- 4. missed abortion; [and]
- 5. similar medical and surgical conditions of comparable severity;[and]
- 6. [**Non-Elective Cesarean Section**;] [and]

**Covered Complications of Pregnancy** do not include

[other than a **Non-elective Cesarean Section**,] will be in or out.

[coinsurance percentage of the ] The coinsurance percentage will range from 5% - 50%.

[**Usual and Customary**] will be in or out.

This will be in or out.

The Maximum Amount will range from \$100 - \$100,000.

This will be in or out. If in, the Deductible will range from \$0 to \$10,000.

This will be in or out.

This will be in or out. If in,

The Maximum Amount will range from \$100 to \$10,000.

This will be in or out. If in:

[six (6)] the number of weeks or months will be inserted will range from 4 weeks to 6 months; [weeks] will be in or out [months] will be in or out.

[**Covered Complications**] will be in or out.

[and] will be in or out.

[post-partum depression] will be in or out.

[after the applicable **Deductible**, as shown on the Schedule, has been met and] will be in or out.

This will be in or out. If in,

The overall Maximum Amount will range from \$100 - \$100,000.

[treatment by a **Physician**] [**Hospital Confinement**] will be in or out.

[when the pregnancy is not terminated] will be in or out.

[and] will be in or out.

[and] will be in or out.

[**Non-Elective Cesarean Section**;] [and] will be in or out.

<p>false labor, occasional spotting, [Physician-prescribed rest during the period of pregnancy,] morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.</p>	<p>This will be in or out.</p>
<p>[Deductible means the amount of Usual and Customary Expenses for Medically Necessary treatment of [Covered Complications][Non-elective Cesarean Sections] that must be incurred by the Insured before [Covered Complications][Non-elective Cesarean Section] benefits become payable. The amount of the Deductible is shown in the Schedule. Covered Complications of Pregnancy benefits are not payable for charges applied to the Deductible.]</p>	<p>This will be in or out. If in, [Covered Complications] [Non-elective Cesarean Sections] will be in or out. [Covered Complications] [Non-elective Cesarean Sections] will be in or out. the Deductible will range from \$0 - \$10,000.</p>
<p><b>Hospital Confined (Hospital Confinement)</b> means admission to a Hospital as an inpatient [for at least twenty-four (24) consecutive hours] by a Physician for a Covered Complication. A Hospital stay that does not result in charges to the Insured is not a Hospital Confinement under this rider unless there is no charge because the Hospital is a United States government facility.</p>	<p>This will be in or out.</p>
<p>[Non-Elective Cesarean Section means an unscheduled cesarean section due to an emergency which puts the life and health of the Covered Person or fetus in jeopardy.]</p>	<p>This will be in or out.</p>
<p><b>Pre-existing Condition</b> means a condition for which an Insured received any diagnosis, medical advice or treatment or had taken any prescription medicines during the [six (6)] months immediately preceding the Covered Complication [unless the condition for which the prescribed medication is taken remains controlled without any change in the required prescription].</p>	<p>[six (6)] The range will be 1 – 24. This will be in or out.</p>
<p><b>Related</b> means [the Insured's Spouse[/Domestic Partner] or other adult living with the Insured], sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.</p>	<p>[the Insured's Spouse[/Domestic Partner] or other adult living with the Insured] will be in or out. If in [/Domestic Partner] will be in or out.</p>
<p>[Usual and Customary Expense(s) (Covered Charges) means an amount(s) that: ...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] (3) does not include charges that would not have been made if no insurance existed [and (4) 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.]</p>	<p>This will be in or out. If in, This will be in or out. [and] will be in or out. This will be in or out. If in, [seventy-five (75%)] the range will be 25% – 100%.</p>
<p><b>EXCLUSIONS:</b> For the purposes of this rider only and in addition to the</p>	<p>Any combination of exclusions 1 through 31 may be in or</p>

<p>General Exclusions in Section IV of the <b>Policy</b>, <b>We</b> will not provide coverage for any of the following:</p> <p>[5. personal comfort or convenience items, such as but not limited to <b>Hospital</b> telephone charges, television rental, or guest meals while confined in a <b>Hospital</b> [or for items taken away or home from the <b>Hospital</b>, [including but not limited to crutches, wheel chairs and walkers] [except <b>Durable Medical Equipment</b>]].]</p> <p>[11.charges that are payable under automobile medical benefits [in excess of [\$5000]].]</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the <b>Policy</b>.</p>	<p>out.</p> <p>This will be in or out. If in:</p> <p>This will be in or out. If in, [including but not...] will be in or out. [except...] will be in or out.</p> <p>This will be in or out. If in: [in excess...] will be in or out. If in, range will be \$500 - \$10,000</p> <p>[not] will be in or out.</p>
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# Administrative Change Endorsement



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

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

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

[This endorsement will be used to make the following types of administrative changes to the **Policy**:

1. **Policyholder's** Name or Address;
2. Addition or deletion of subsidiaries or affiliates of the **Policyholder**;
3. Changes to the class(es) of eligible persons;
4. Addition or deletion of Benefit Riders; ~~or~~
5. Increase or decrease in ~~Benefit Coverage~~ Amount(s); ~~or~~
6. Renewal of the Policy.

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

Effective Date: \_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_

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