There are 5 evaluators

George Ivory

Thomas J. Calhoun

Machell Stockstill

Billy Scott

Carla Williams

There are three (3) responses

Proposal 1 – CBIZ

Proposal 2 – Gallagher

Proposal 3 -DrHub

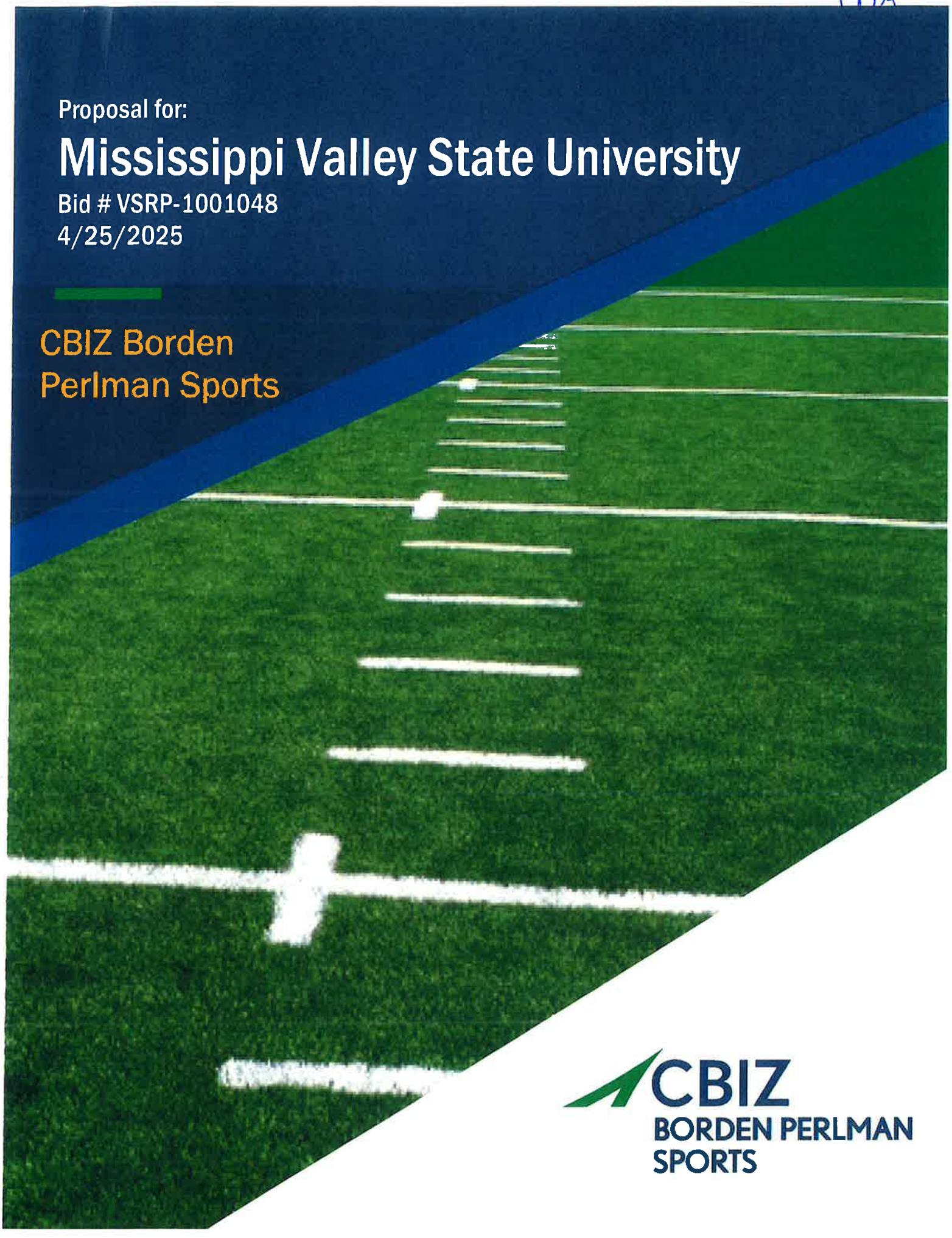
Proposal for:

Mississippi Valley State University

Bid # VSRP-1001048

4/25/2025

CBIZ Borden Perlman Sports



CBIZ BORDEN PERLMAN SPORTS

4/25/2025

Joyce Dixon
Business & Finance Department
Mississippi Valley State University
14000 Hwy 82-W #7244
Itta Bena MS 38941-1400
Re: Response to Inquiry

Dear Joyce,

Thank you for considering CBIZ Borden Perlman Sports to join your team and for the opportunity to be a partner in the future. The attention and resources put towards creating the best policies and practices comes with increasing medical expenses that need to be managed efficiently. Our goal will be to collaborate with your team to create, recommend and implement the best possible outcomes for the Mississippi Valley State University and their student-athletes.

Our team has the industry knowledge, influence, and experience to put the best risk transfer options forward to Mississippi Valley State University while offering and promising a completely transparent compensation model that is a fee-based approach. We work with almost every insurance carrier in this market and can bring a wide array of proposals when needed.

Insurance products are valuable tools that provide the ability to budget, protect finances, and create administrative efficiencies. These products are not always the answer but our consultative approach to creating solutions will guide your team and ours to decide on the appropriate path to managing your plans.

Available Insurance Products

Traditional basic accident medical – various deductibles

- **Student Health Insurance Plans both fully and self-insured**
- **Aggregate Deductible Accident Only**
- **Aggregate Deductible Comprehensive Accident and Sickness**
- **Compliant Individual Health Insurance Plans**
- **International Individual Health Insurance Plans**
- **Catastrophic Accident Plans**

We look forward to getting to work for the Mississippi Valley State University, and we thank you for the opportunity.

Sincerely,

Dave Icenhower
Collegiate Risk Advisor

Kelly Myers
Director of Sales

THE CBIZ DIFFERENCE

CBIZ Borden Perlman Sports – General Information about the Firm

The Borden Perlman Sports Department was founded in 1990 but our company's history began 100 years ago. In January of 2021, we joined CBIZ, one of the nation's largest publicly owned property and casualty insurance brokers. As CBIZ Borden Perlman Sports, we continue to deliver on our mission of providing insurance expertise, now with the expanded offerings of a national organization. For over 30 years, we have been providing superior customer service, focused innovation, and sincere dedication to each collegiate community we serve.

Reporting and Analytics

CBIZ Borden Perlman and its' third-party administrator have extensive reporting capabilities and will analyze data to pin-point problem areas. We willcustomize reports specific to your needs. These reports will be provided on a monthly frequency or more frequently if requested.

Oversight of Claims Payor / TPA Services

CBIZ Borden Perlman will oversee claims services by conducting periodic claims audits. These audits will include, but not be limited to; accuracy of the claims paying service, timely payment of clean claims, monitoring of the communication process between the TPA and the school, and the implementation of cost containment techniques through Borden Perlman Health Advocate (BPHA).

Advice and Assistance

CBIZ Borden Perlman will consult with athletics staffon all issues affecting thebenefits and financing of the services provided. We will constantly monitor the financial health of the program, as well as issues that affect student-athlete welfare regarding medical expense. The Sports Team will communicate on a regularbasis with athletics staff todiscuss any issues associated with medical expenses.

Best Practice Consulting

CBIZ Borden Perlman has a certified athletics trainer onstaff, who will work directly with you to provide consultation to the sports medicine staff. Our Trainer can assist regarding best practices for claims filing, cost containment, synergy with injury tracking systems and the TPA, as well as any other issues related to our medical insurance and service providers.

SERVICES INCLUDED IN OUR FEE BASED STRUCTURE

List of Services:

- Placement of Third-Party Administrator or other claims adjusting and payment service
- Standard claims reporting or customized on a regular agreed upon schedule (see samples)
- Marketing and placement of the agreed upon insurance plan
- Advocacy for the university involving administrative processes and claims resolution
- Constant performance evaluation of cost containment platforms
- Policy review and performance evaluation on an as needed basis
- Review of fee schedules with local providers
- Negotiation and communication with local providers on behalf of the university
- Insurance Verification on current and in-coming Student-Athletes (SA's) (see below)
- Placement of appropriate domestic or international plans for SA's
- Best practices review and education with Sports Medicine staff on claims handling effectiveness regarding medical expense

Our services are not limited to those above. Should our collaboration with the Mississippi Valley State University (MVS) team indicate that there needs to be additional services not listed above we will do everything we can to accommodate MVS without an increase in cost. We want to be certain that we are meeting your needs and providing appropriate resources that benefit this program.

****The CBIZ Borden Perlman Sports fee will be agreed upon by both parties and can be guaranteed for multiple years. Any change in the fee amount and the reasons for the change will be discussed with MVS stakeholders at the renewal meetings.

Primary Insurance Verification

CBIZ Borden Perlman Sports offers an easy way to verify the validity and benefits of your student-athletes primary insurance. The process is easy and helps mitigate expenses from uninsured or underinsured student-athletes.

- Verify validity of primary insurance
- Benefits can be checked monthly, quarterly, and upon request
- Ability to check single student-athletes in real time (Transfers, Walk-ons, Try-Outs; Insurance changes, etc.)
- If verification isn't possible electronically from spreadsheet template that we would provide you, then we will manually check it

YOUR TRUE BROKER ADVOCATE

WHY?

The Mississippi Valley State University needs an advocate in the space of your athletic secondary accident plan design. This would include all the intangibles under the umbrella of this program, from the traditional ICS plan designs, from student-athlete domestic and international coverage, your under-insured or non-insured student-athletes and any other specific risk factors that could affect your program. CBIZ Borden Perlman Sports is the choice that is a true advocate for our clients. Here is why:

- **OUR FEE IS PAID BY YOU. Insurance brokers and Third-Party Administrators (TPA's) are typically paid by the insurance carrier which presents an inherent conflict when developing coverage terms/ conditions and solving sticky claims issues.**

- **When a TPA interpretation is controlled or influenced by the insurance carriers audit team you need an advocate that fights for the broadest interpretations that benefit your institution and Student Athletes. CBIZ will be the "watchdog" over the entire program.**

Our expertise and experience for 32 years in this space is our basis for the strong sense of advocacy we can provide. We will have your best interest in mind daily because our only motivation is to keep this program running the way you want it too. Having peace of mind that you have a partner and an advocate behind your program design and plan should provide confidence that the Mississippi Valley State University has help to manage any situation and nuance that comes during the plan year.

Our services ensure consistency and timeliness to our schools, and we expect the TPA's that would be managing your claims services to reflect that as well. CBIZ Borden Perlman Sports on behalf of the Mississippi Valley State University requires the same professionalism to be demonstrated from your Third-Party Administrator and will constantly monitor that objective is being met.

EXAMPLES OF OUR SCHOOLS WE HAVE FINANCIALLY STABILIZED

Jacksonville State University - Jacksonville, Alabama

- *Client since 2016*
- Consulted, negotiated, and recommended fee schedule with Andrews Sports Medicine with no re-pricing fees
- Same with Physical Therapy (PT) groups
- Moved plan from Fully Insured to Aggregate Deductible model after negotiating these deals- saving well over 200k per plan year- cost is stable
- Implemented and provided health insurance plan for International Student-Athlete's (SA's)
- Best practices training for Sports Medicine staff on claims handling and filing helping to mitigate claims expense

Wagner University - Staten Island, NY

- *Client since 2020*
- Consulted, negotiated, and recommended domestic and international health plans covering intercollegiate sports
- Moved to an aggregate deductible structure that saved tens of thousands per plan year- cost and the cost has reduced every year

University of Northwestern Ohio - Lima, Ohio

- *Client since 2015*
- Began consultative services regarding increased medical expense due to additional sports and increased participation- cost was estimated to be over 400k status quo- moved to implement some mitigation strategies
- Recommended mandatory student accident plan covering intercollegiate sports coverage (1,500) which saved tens of thousands per plan year
- Began insurance verification to catch domestic SA's without coverage
- Implemented domestic hard wavier plan and aggregate deductible plan reducing cost to the University by 100k per plan year

EXAMPLES OF OUR SCHOOLS WE HAVE FINANCIALLY STABILIZED

University of Toledo - Toledo, Ohio

- *Client since 2010*
- Negotiated fee for service arrangement university medical center which is on file at Third Party Administrator (TPA) with no repricing fees
- Constant review of other provider relationships and the reimbursement model
- Have been able to keep the aggregate plan with the same carrier originally reducing cost and keeping cost within an 5% to 10% fluctuation since 2010

Arizona State University - Tempe, Arizona

- *Client since 2020*
- Was self-funded and self-administered (no TPA) for many years because of a high deductible plan
- Moved self-funded expense an experienced TPA to which provided reporting not available previously
- Reviewed and negotiated with various providers to obtain favorable reimbursement models
- Placed an international student plan that transfer the sports risk to an insurance plan
- Implemented an aggregate plan for all medical expenses generated by the SA
- On the committee to hire the current insurance coordinator and then train to handle claims for student athletes and work daily to mitigate medical expenses. Currently have multiple communications weeklies to keep this on track

Warner University - Lakeland, Florida

- *Client since 2016*
- Negotiated a capitation arrangement with orthopedic group which removed those expenses from the secondary insurance equation, thus stabilizing the cost generated by the provider

SAMPLE REPORTS

Monthly Paid Claims & Treasury Summary

XYZ University
Claim Account Summary

Paid Claims Summary					
Policy Year	2019-20	2020-21	2021-22	2022-23	2023-24
Carrier	Hartford	Hartford	Hartford	Hartford	Hartford
Aggregate Deductible	$250,000	$255,000	$255,000	$255,000	$250,000
Aggregate Deductible Paid Claims	$176,967.59	$160,989.33	$162,232.01	$198,991.35	$47,399.66
Discretionary Paid Claims	$0.00	$0.00	$2,947.00	$0.00	$0.00
Policy Paid Claims	$0.00	$0.00	$0.00	$0.00	$0.00
Total Paid Claims	$176,967.59	$160,989.33	$165,179.01	$198,991.35	$47,399.66

Claims Funding Account Summary	
Account Balance as of 2/1/2024:	$34,218.75
Claims Funding Deposits	
1/31/2024	$30,000.00
11/22/2023	$50,000.00
7/25/2023	$50,000.00
2/10/2023	$50,000.00
2/1/2023	$25,000.00
1/16/2023	$42,774.85
11/4/2022	$25,000.00
9/28/2022	$20,000.00
8/1/2022	$95,000.00
10/22/2021	$50,000.00
9/24/2021	$46,308.34
4/6/2021	$24,800.00
2/1/2021	$25,000.00
9/1/2020	$85,000.00
1/29/2020	$50,000.00
10/30/2019	$75,000.00
8/29/2019	$39,862.50
Funding Total	$783,745.69

SAMPLE REPORTS

Paid Claims by Sport

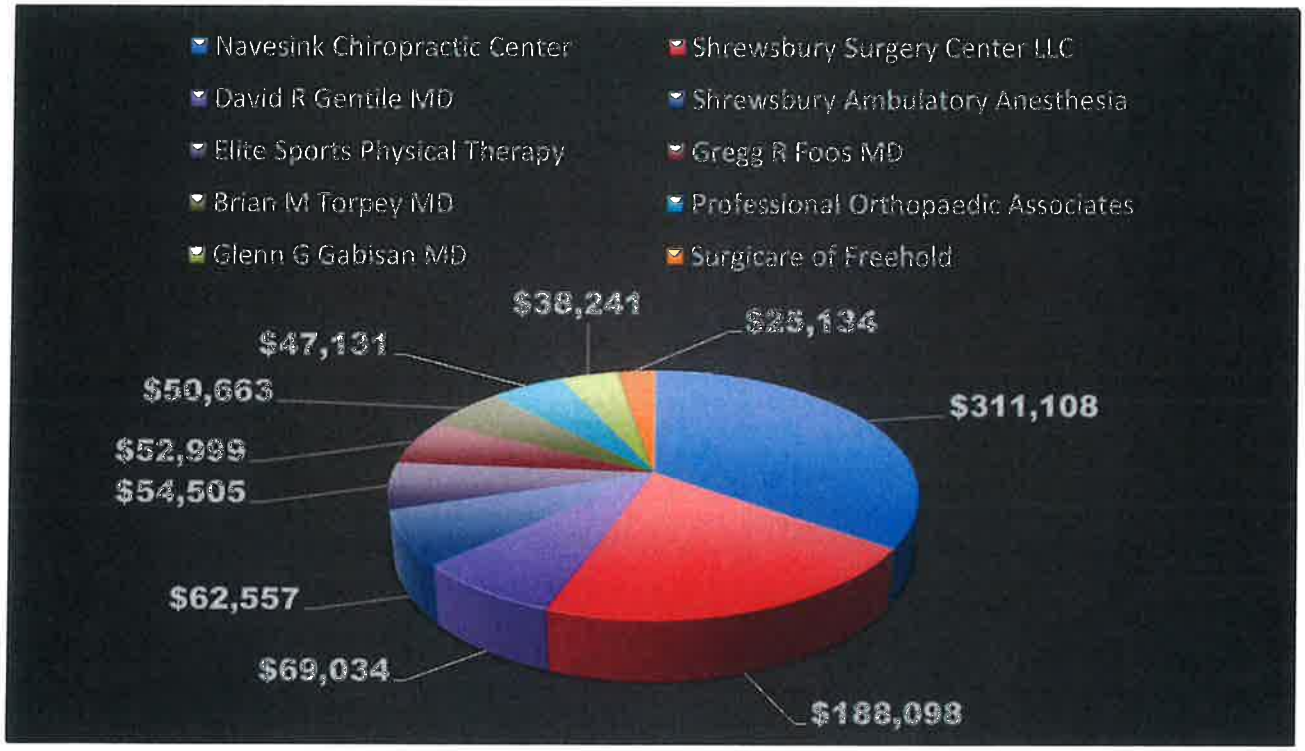
Sport	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	Combined	% of Total
Football	$90,360.95	$94,205.31	$89,549.38	$126,892.05	$30,043.00	$431,050.69	57.51%
Soccer	$42,599.44	$7,814.65	$23,595.65	$12,947.24	$1,296.28	$88,253.26	11.77%
Basketball	$10,991.05	$6,197.09	$23,487.54	$35,271.98	$6,141.68	$82,089.34	10.95%
Track & Field	$6,531.26	$28,167.23	$928.93	$9,132.49	$60.00	$44,819.91	5.98%
Baseball	$8,661.82	$12,552.04	$2,186.54	$4,011.92	$1,793.56	$29,205.88	3.90%
Volleyball	$6,761.90	$1,978.57	$8,609.75	$926.39	$1,382.98	$19,659.59	2.62%
Tennis	$4,357.79	$3,130.02	$6,224.60	$1,397.07	$2,122.33	$17,231.81	2.30%
Softball	$2,206.37	$1,879.86	$5,106.67	$1,075.98	$1,095.57	$11,364.45	1.52%
Cheerleading	$4,497.01	$2,241.43	$522.03	$2,782.09	$836.67	$10,879.23	1.45%
Cross Country	$0.00	$1,892.91	$4,967.92	$812.49	$2,627.59	$10,300.91	1.37%
Golf	$0.00	$930.22	$0.00	$3,741.65	$0.00	$4,671.87	0.62%
TOTALS	$176,967.59	$160,989.33	$165,179.01	$198,991.35	$47,399.66	$749,526.94	100.00%

Paid Claims by Type of Service

Charge Type	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	Combined	% of Total
Facility - Outpatient Surgery	$30,028.90	$41,200.06	$35,826.36	$39,091.73	$5,225.01	$151,372.06	20.20%
Physical Therapy	$56,536.17	$27,508.83	$17,380.44	$28,547.48	$4,601.91	$134,574.83	17.95%
Surgeon Charges	$18,848.11	$30,639.23	$27,251.89	$28,219.57	$2,073.36	$107,032.16	14.28%
Network Repricer	$32,143.24	$11,872.75	$16,335.23	$26,033.92	$19,418.97	$105,804.11	14.12%
Orthotics	$10,313.86	$13,885.82	$21,554.40	$16,174.53	$4,362.54	$66,291.15	8.84%
Facility - Outpatient Non-Surgical	$12,425.60	$8,734.42	$14,471.20	$10,043.24	$1,910.84	$47,585.30	6.35%
CT/MRI	$3,116.64	$6,954.57	$6,172.65	$16,421.79	$2,298.99	$34,964.64	4.66%
Office Visits	$4,259.11	$4,459.90	$7,740.76	$9,934.30	$4,186.87	$30,580.94	4.08%
Assistant Surgeon	$750.64	$7,386.76	$5,307.72	$5,797.40	$103.63	$19,346.15	2.58%
X-rays	$3,466.56	$4,433.74	$3,960.46	$5,596.53	$1,083.94	$18,541.23	2.47%
Anesthesia	$2,791.33	$2,784.99	$8,172.62	$4,713.18	$0.00	$18,462.12	2.46%
Facility - Inpatient	$0.00	$0.00	$0.00	$7,784.33	$0.00	$7,784.33	1.04%
Dental	$1,028.00	$0.00	$0.00	$0.00	$2,133.60	$3,161.60	0.42%
Ambulance	$517.00	$1,001.10	$539.46	$0.00	$0.00	$2,057.56	0.27%
ER Physician Charges	$14.30	$91.17	$327.51	$545.24	$0.00	$978.22	0.13%
Labs	$705.07	$0.00	$0.00	$0.00	$0.00	$705.07	0.09%
Consultations	$0.00	$30.00	$135.00	$69.07	$0.00	$234.07	0.03%
Miscellaneous	$23.06	$5.99	$2.73	$0.00	$0.00	$31.78	0.00%
Prescriptions	$0.00	$0.00	$0.58	$19.04	$0.00	$19.62	0.00%
TOTALS	$176,967.59	$160,989.33	$165,179.01	$198,991.35	$47,399.66	$749,526.94	100.00%

SAMPLE REPORTS

Paid Claims by Top 10 Medical Providers



Paid Claims by Point-in-Time

Policy Year	Paid Claims as of 7/1/2019	Paid Claims as of 7/1/2020	Paid Claims as of 7/1/2021	Paid Claims as of 7/1/2022	Paid Claims as of 7/1/2023
2019-2020	$190,011	$358,261	$390,926	$393,736	$393,646
2020-2021		$137,728	$253,254	$290,021	$291,500
2021-2022			$53,328	$262,424	$292,645
2022-2023				$94,608	$242,805
2023-2024					$152,634

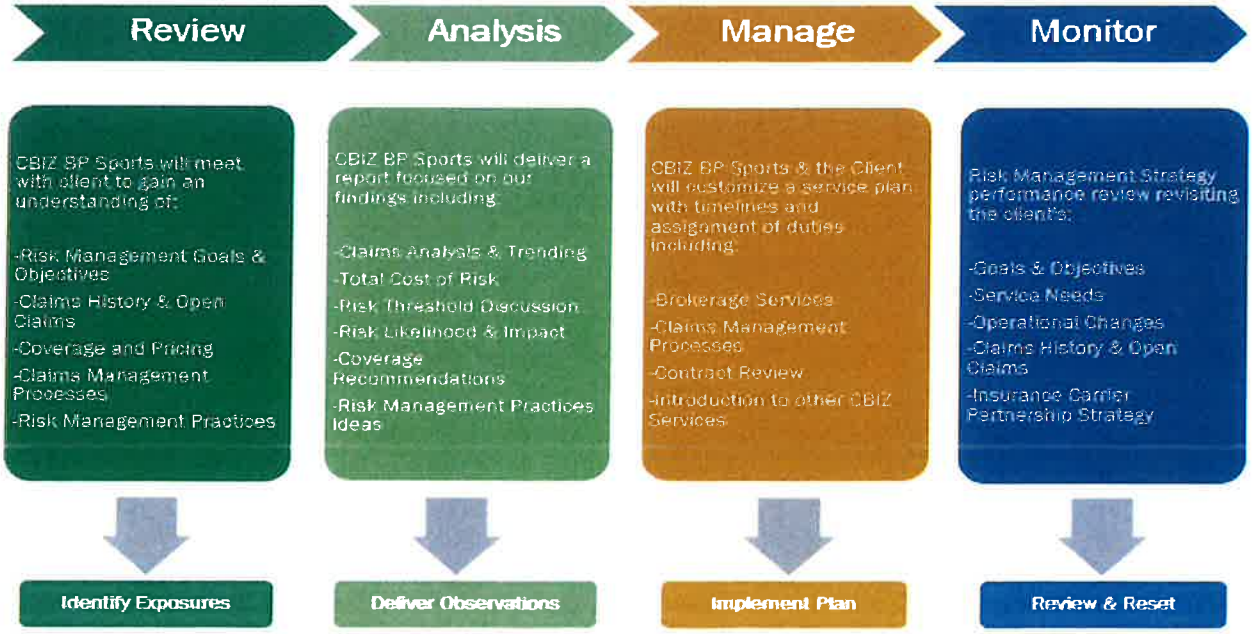
RISK ASSESSMENT FOR OUR SCHOOLS

Risk Management Approach

CBIZ Borden Perlman Sports is committed to serving the needs of its insurance and risk management clients. What sets us apart is our unique ability to provide enterprise-wide risk consulting expertise to the clients we serve. We view risk holistically, binding together all elements of traditional and emerging risk management needs with human capital management and financial performance.

Our approach to client service and work product delivery is first and foremost collaborative in nature. It begins with gaining a thorough understanding of the client's current structures, needs, goals, and development plans through an interview and assessment process. We then work to identify opportunities for sustained process and/or performance improvement, develop solutions based on our experience, best practices, etc., and implement the strategies mutually chosen by the client and CBIZ Borden Perlman Sports. Importantly, we will also assist the client in measuring success after implementation and make amendments to maximize outcomes.

Our approach closely follows the chart depicted below. However, given that no organization's risk profile is static and each client views risk differently, we tailor our approach to ensure our service team is engaged in an active dialogue with you, reviewing the details of the risk management and assessment process to provide you with a customized report and our best recommendations and advice.



RISK ASSESSMENT FOR OUR SCHOOLS

Our risk management approach closely follows the flow chart depicted above. However, given that no organization's risk profile is static and each client views risk differently, we tailor our approach to ensure our service team is engaged in an active dialogue with you, reviewing the details of the risk management and assessment process to provide Mississippi Valley State University with a customized service plan.

Our goal is to:

- Minimize cost while maintaining optimal coverage, market security, and overall service
- Balance Mississippi Valley State University risk appetite with the appropriate program design
- Provide data to aid in assessing options
- Establish clear guidelines of communications between Mississippi Valley State University, CBIZ BP Sports and all participating providers, Third Party Administrators (TPA's), and Carriers
- Assist in establishing and maintaining strong insurer relationships
- Attack risk drivers through pre-loss, risk finance, and post-loss solutions
- Engage and coordinate all available resources from your chosen plans and policies to improve service efficiencies and support your risk management team

Marketing & Placement

CBIZ Borden Perlman Sports is a dedicated group focused on fostering carrier relationships. Our strength lies in our ability to deliver results for our clients based on these relationships. Our unique approach to generating a working relationship between carrier and client is also vastly different from many traditional brokers who strive to keep a separation between client and carrier. We believe that this approach lends itself to enhancing our relationship with the carrier and the carrier's relationship with the client.

As a national broker, CBIZ Borden Perlman Sports has access to and excellent relationships with key national insurance carriers. We work diligently to maintain the preferred status with these carriers. Daily interactions with insurers enable our professionals to understand market cycles and sense the slightest shift in market trends, as well as the attitudes of individual insurers.

INSURANCE CARRIER RELATIONSHIPS

Carrier Selection

We strive to serve as the Risk Management experts for our university clients across the country. We represent the majority of carriers providing coverage to university secondary accident plans, domestic and international plans. We leverage these relationships to make sure our clients can secure the broadest insurance coverage possible at the most reasonable cost. When we market your insurance program, we are transparent. We share all the results, point out coverage differences and concerns and make recommendations so can make informed decisions.

Since we have been collaborating with the same carriers for several years, we have also established strong relationships at all levels in their organizations. We have access to their decision-makers and excellent working relationships with claims and loss control personnel. These strong carrier relationships also enable us to intervene and obtain favorable outcomes when issues may arise as to the coverage of a claim or complying with a loss control recommendation.

There are many factors to consider when choosing an insurance carrier such as their AM Best rating, historical financial stability and their long-term commitment to the industry sector or product line. Our team uses all available resources, including AM Best and S&P Global insurer ratings, to monitor the carrier's financial strength. CBIZ Borden Perlman Sports recommends that all clients use only "A" rated insurers wherever and whenever possible.

Our dedicated team will work with you to develop and execute a risk management and insurance program that meets your needs, matches your risk tolerance, and secures the most competitive rates, terms, and conditions available in the marketplace. We will review all existing insurance policies as well as current operational and contractual methods for mitigating or preventing risks. We will report our findings to you along with recommendations for improvement. We will then collaborate with your athletic administrative team and sports medicine team to develop insurance and alternative risk financing solutions for your consideration.

NEGOTIATION AND RENEWAL PROCESS

Negotiate annual renewal of existing coverages/underwriting

As national industry leaders experienced in all risk management and risk transfer approaches, we are positioned to negotiate with the most competitive insurance carriers to get the best insurance products and pricing for Mississippi Valley State University. In preparation for each renewal, we will meet with your team to gather the required underwriting information. CBIZ Borden Perlman Sports strives to make this as easy as possible for Mississippi Valley State University in a variety of ways. Our renewal process follows a six-step progression centered on reviewing and fine tuning a policy customized to you.

Renewal Process

1. Review the current risk management strategy and insurance plan prior to discussing goals
2. Develop an insurance budget and review rates
3. Present innovative cost savings ideas based on industry trends
4. Identify carrier alternatives
5. Evaluate renewals for plan accuracy, completeness, and consistency
6. Negotiate renewal terms, conditions, and alternative plan design options

Transparency and communication are one of the core values we will always provide to our schools, and this results in bringing valuable information to the Mississippi Valley State University so that your specific goals and plan design are met.

We develop a framework for all activities involved in the delivery of our brokerage and risk management consulting services. As presented in an earlier section of this report, all our client service plans are predicated on a detailed timeline. Upon appointment as the broker/advisor to Mississippi Valley State University, the CBIZ Borden Perlman Sports team will work with you to develop a detailed timeline, identifying all tasks, commencement dates and due dates, and assigning accountable parties, including CBIZ Borden Perlman Sports, Mississippi Valley State University, prospective carriers and TPA's, and other service providers.

CLAIMS MANAGEMENT AND PROCEDURES

Claims Handling

Claims Management Policies & Procedures

CBIZ Borden Perlman Sports works closely with the various insurance carriers or third-party administrators involved with our clients to ensure "best practices" are followed to process, mitigate and effectively and efficiently close claims.

We will:

- Make certain there is a coordinated effort for financial wellness and administrative concerns between the CBIZ Borden Perlman Sports account executive, the designated CBIZ Borden Perlman Sports claims' Third-Party Administrator (TPA), our risk consulting team, the insurance carrier, and Mississippi Valley State University.
- Work with Mississippi Valley State University to review current claims management policies and procedures. Where applicable, we will collaborate to revise and implement claims management guidelines to improve the reporting and recording of incidents, potential claims, and filed claims.
- Summarize claims and loss ratios monthly, in which Mississippi Valley State University would get a detailed report.
- Conduct pending claim review meetings between your insurers' claims representatives and Mississippi Valley State University's administrative and sports medicine team with the stated goal of reviewing claim activity.
- Provide a comprehensive review of your policy involved in a loss and monitor the claims process to ensure a favorable resolution to your claim. We will advocate on behalf of the Mississippi Valley State University to ensure an effective claim outcome.
- Provide loss analysis that identifies high dollar claims and frequency.
- Analyze current reimbursement models and constantly look to improve when possible.
- Establish a timeline for periodic reporting of all open and reserved claims.
- Communicate with your TPA to make sure claims are settled efficiently and assist in acquiring necessary documents from your providers for settling claims if necessary.
- Make our CBIZ Borden Perlman Sports team and claim consultants available to your team 24 hours a day.

CERTIFICATION OF OWNERSHIP INTEREST IN CONTRACTOR

Mississippi Board of Trustees of State Institutions of Higher Learning (IHL)

CERTIFICATION OF OWNERSHIP INTEREST IN CONTRACTOR

I. Submission Information *(Section I. A. through C. is to be completed by the UNIVERSITY prior to sending to the Contractor. Section I.D. is to be completed by the CONTRACTOR.)*

A. Institution/University Name:	Executive Office		
B. Submission Date:	*Month*	*Day*	*Year*
	May	1	2025
C. Agenda (Month/Year):	June	19	2025
D. Contractor's Legal Name:	CBIZ Benefits & Insurance Services, Inc.		

II. Submitted for the following Board Committee *(Section II is to be completed by the UNIVERSITY prior to sending to the Contractor.)*

X	Budget, Finance and Audit
	Real Estate
	Other (specify)

III. List of Owners *(Sections III and IV are to be completed by the CONTRACTOR.)*

The following is a listing of all individuals and other entities that have a financial interest of 10% or more in the ownership of the above named contractor:

CBIZ Operations, Inc. - 100%

The following is a listing of all parent companies of the above named contractor that have a financial interest of 10% or more in the ownership of the contractor:

CBIZ, Inc. - 100% Interest in CBIZ Operations, Inc.

IV. Certification

The undersigned certifies that he/she is a lawful official representative of CBIZ Benefits & Insurance Services, Inc. (insert legal name of contractor as noted above) and further certifies that the above is a listing of all individuals, other entities, and parent companies that have a financial interest of 10% or more in the ownership of the Contractor.

Name of Contractor Representative:	Debra A. Blecha
Title of Contractor Representative:	Vice President
Signature:	Debra A. Blecha
Date:	4/10/2025

BENEFIT SUMMARY

Who is Covered	
All intercollegiate student athletes, student managers, student trainers, student coaches and guest recruits of the Policyholder	
Description of Activity	
While participating in the scheduled, sponsored and approved intercollegiate sport activities of the Policyholder. This coverage includes while traveling directly and uninterruptedly to and from such activities. Coverage for guest recruits is while participating in on-campus evaluations, including participating in play, practice, drills and other similar activities as governed by the NCAA.	
Benefits & Limits	
Accidental Death & Dismemberment	$10,000
Accident Medical Expense Per Injury	$90,000
Deductible Per Injury	$0
Medical Paid As	Excess
Benefit Period	104 Weeks
Expanded Medical	Included
Re-Aggravation or Re-Injury	Included
Heart & Circulatory	Included
HMO/PPO	Included
Pre-Existing Conditions	Included
Off-Season Conditioning	Included
Covered Sports	
Baseball, Basketball, Cross Country, Football, Tennis, Track & Field, Cheer, Soccer, Softball, Volleyball	

MARKETING SUMMARY

All insurance carriers that we are presenting are rated "A" or higher by A.M. Best.

Carrier	AM Best Rating
AIG (National Union Fire Insurance Company of Pittsburgh, PA)	A (Excellent)
Hartford Fire Insurance Company	A+ (Superior)

Aggregate Deductible Options

Carrier	Claims Administrator	Specific Deductible	Aggregate Deductible	Premium & Administration Cost	Total Potential Maximum Cost
Hartford	NAHGA	$0	$200,000	$54,494	$254,494
Hartford	A-G Administrators	$0	$200,000	$60,494	$260,494
AIG	NAHGA	$0	$229,289	$69,300	$298,589
AIG	A-G Administrators	$0	$229,289	$76,179	$305,468
AIG	NAHGA	$10,000	$120,000	$53,585	$173,585
AIG	A-G Administrators	$10,000	$120,000	$57,185	$177,185
Hartford	NAHGA	$10,000	$120,000	$100,459	$220,459
Hartford	A-G Administrators	$10,000	$120,000	$104,059	$224,059
Hartford	NAHGA	$10,000	$150,000	$64,763	$214,763
Hartford	A-G Administrators	$10,000	$150,000	$69,263	$219,263

*There will be a additional $11,000 charge included for any plan with a $10,000 specific deductible.
(This is already included in the quotes above)

SELF-INSURED PLAN

CBIZ Borden Perlman Sports is committed to serving the needs of its clients. If MVS would prefer to continue with a completely self-insured plan, we would provide the following services:

CBIZ Borden Perlman Sports Services

- Provide primary insurance verification
    - Twice per year
- Securing Primary Insurance for Athletes
    - Individual Primary Health Insurance
    - Individual Primary Sports Accident Insurance
    - International Group Health Insurance that Includes Sports Coverage
    - International Individual Health Insurance that Includes Sports Coverage
    - Travel Accident
- Development of Plan Document
    - We will collaborate with MVS and draft a plan document appropriate for the administration and payment of medical expense
    - Plan document will be on file with the claims administrator identified below and will govern all claims payments
    - Client will have the discretion of having the claims administrator pay claims that fall beyond the scope of the plan document when notified in writing
- Reporting and Analytics
    - Will review/analyze data to pinpoint problem areas
    - Monthly reporting detailing paid claims per injury and funding account balance
    - Custom reports like the samples provided are available as well
- Cost Containment Strategy
    - Contracting with preferred/frequent providers
    - Accessing network discounts through passive repricing
    - Negotiating single case agreements on larger bills

CBIZ BORDEN PERLMAN SPORTS

YOUR TEAM

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ABOUT CBIZ

Corporate Name: CBIZ, Inc.

CBIZ Corporate Headquarters is in Ohio.

6801 Brecksville Road, Door N
Independence, OH 44131
(216) 447-9000

Business Name: CBIZ Insurance Services, Inc. dba CBIZ Borden Perlman

CBIZ Insurance Services, Inc. has offices across the country. The office that would primarily provide services to the Mississippi Valley State University is based in Ewing, NJ.

CBIZ Borden Perlman Sports
200 Charles Ewing Blvd, Suite 330
Ewing, NJ 08628

Primary Contacts

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Financial Status

CBIZ has been operating as a professional services organization since 1997. We have grown and prospered by acquiring extraordinarily successful accounting, benefits, valuation, and other service firms throughout the U.S. Since August 2006, CBIZ stock has been publicly traded on the New York Stock Exchange under the ticker symbol "CBZ."

Visit www.cbiz.com and go to the "Investors" tab to find all of our SEC filings.

CBIZ Insurance Services will surpass the $100 Million revenue mark this year making us a Top 30 U.S. Broker. Our growth has afforded us the opportunity to add talent and resources that best meet our client's objectives. We are pleased to say that any changes would be ones that would further enhance our service plan.

HARTFORD FIRE INSURANCE COMPANY
One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

THE HARTFORD

SCHEDULE

POLICY NUMBER:	**XXXXX**
POLICYHOLDER NAME:	**XXXXX**
POLICYHOLDER'S ADDRESS:	XXXXX XXXXXX
Previous Policy No:	N/A
Policy Period:	Policy Effective Date: XXXXX Policy Anniversary Date: XXXXX Policy Termination Date: XXXXX

PREMIUM

Policy Premium:	XXXXX
Premium Mode:	annually

DESCRIPTION OF ELIGIBLE CLASS(ES):

Class	Description Of Class(es)	Applicable Hazard Riders	Applicable Benefit Riders
1	**All registered intercollegiate student athletes, student managers, student trainers, student coaches and mascots of the Policyholder.**	**N/A**	**B1, B28**
2	**All guest recruits of the Policyholder.**	**N/A**	**B1, B28**

COVERED ACTIVITIES means:

XXXXX

BENEFITS AND AMOUNTS

Class 1 and 2	**PRINCIPAL SUM**
Accidental Death & Dismemberment	XXXXX

EXCESS COVERAGE APPLIES

BENEFIT RIDER(S)

Identifier	Form Number	Description
B-1	Form BSR PA-9935 (GA)	Accident Medical Expense Benefit Rider
B-28	Form BSR PA-9965	Heart or Circulatory Benefit Rider

BLANKET ACCIDENT POLICY

HARTFORD FIRE INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

THE HARTFORD

Policyholder: XXXXX
Policy Number: XXXXX

We will pay benefits according to the conditions of this Policy.

This is a legal contract between the Policyholder and Us. We agree to provide the rights and benefits of this Policy according to its conditions and provisions.

This Policy begins on the Policy Effective Date shown in the Schedule and continues in effect until the Policy Termination Date as long as premiums are paid when due, unless otherwise terminated as further provided in this Policy. If this Policy is terminated, insurance ends on the date to which premiums have been paid. After the Policy Termination Date, this Policy may be renewed for additional periods of time by mutual written consent between Us and the Policyholder at the premium rates set by Us for the renewal period.

PLEASE READ THE POLICY CAREFULLY.

This Policy is delivered in and governed by the laws of the Policy issue state. This Policy may be inspected at the office of the Policyholder.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

THIS IS A LIMITED BENEFIT POLICY.
IT PROVIDES BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENT ONLY. IT IS NOT INTENDED TO COVER ALL MEDICAL COSTS.

THIS POLICY DOES NOT COVER MENTAL ILLNESS

Signed for Hartford Fire Insurance Company at Hartford, Connecticut

Kevin Barnett, *Secretary*

Douglas Elliot, *President*

EXCESS INSURANCE

Non-Participating

TABLE OF CONTENTS

DEFINITIONS

Accident, Accidental means a sudden, abrupt, and unexpected event.

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

Ambulatory Surgical Center (ASC) or **Ambulatory Medical Center** means a licensed healthcare facility where surgical procedures or medical Treatment that does not require an overnight Hospital stay are performed by a Physician. The facility must:

1) be under the direct supervision of a Physician;
2) provide Treatment by Physicians and/or Medical Professionals; and
3) have written agreements in place with one or more Hospitals to immediately accept patients who develop complications.

An ASC is also known as an outpatient surgery center or a same day surgery center.

Automobile means a self-propelled private passenger motor vehicle with four or more wheels that is of a type both designed and required to be licensed for use on the highways of any state or country. Automobile includes, but is not limited to:

1) a sedan;
2) station wagon;
3) sport utility vehicle; and
4) a motor vehicle of the pickup, panel, van, camper, or motor home type.

Automobile does not include a mobile home or any motor vehicle that is used in mass or public transit.

Benefit Plan means a policy or other benefit or service arrangement for medical or dental care, or providing accident or health coverage, under any of the following:

1) individual, group or blanket coverage, whether on an insured or self- funded basis;
2) Hospital or medical service organizations;
3) health maintenance organizations;
4) labor-management plans;
5) employee benefit organization plans;
6) association plans.

Coinsurance means the percentage of the Usual and Customary Charges incurred for Covered Medical Services payable by Us after the Deductible has been satisfied.

Coma, Comatose means a profound state of unconsciousness from which the Insured Person cannot be aroused to consciousness by external or internal stimulation, as determined by a Physician.

Common Carrier means any air, land or water motorized Conveyance operated under a license for the transportation of fare-paying Passengers, including ridesharing programs. Common Carrier does not include courtesy transportation for which a charge is not made or cruise ships at sea more than 24 consecutive hours or any Conveyance, regardless of whether the Conveyance is licensed that is hired or used for a sport, gamesmanship, contest, or recreational activity. These Conveyances can include, but are not limited to, race cars, bobsleds, hunting vehicles, sightseeing vehicles, helicopters, fishing boats, parasails, paragliders, and boat cruises operating beyond 12 hours.

Complications of Pregnancy means any condition, whether or not a pregnancy is terminated, that requires Hospital Confinement and whose diagnosis is distinct from pregnancy but is adversely affected or caused by pregnancy. Examples include: acute nephritis; cardiac decompensation; disease of the endocrine, hemopoietic, nervous or vascular systems; ectopic pregnancy that is terminated; hyperemesis gravidarum; missed abortion; nephrosis; non-elective caesarean section; spontaneous termination of pregnancy that occurs during a period of gestation when a viable birth is not possible; or any similar condition(s) of comparable severity.

This definition does not include: elective caesarean section unrelated to a diagnosed complication of pregnancy; false labor; morning sickness; multiple gestation pregnancy; occasional spotting; physician prescribed rest during pregnancy;

pre-eclampsia; any similar condition(s) associated with a difficult pregnancy but not considered a classifiable, distinct complication of pregnancy; or any other condition associated with pregnancy but has not been diagnosed by a Physician as a complication of pregnancy as defined.

Confined, Confinement means the assignment to a bed in a medical facility for a period of at least 24 consecutive hours.

Consumer Price Index (CPI) means the index published by the Department of Labor which measures on a periodic basis (usually monthly) the change in the cost of typical urban wage earners' and clerical workers' purchase of certain goods and services.

For the purpose of this benefit, the percentage change in the CPI means the difference between the current year's CPI as of October 31, and the prior year's CPI as of October 31, divided by the prior year's CPI.

Conveyance means any motorized craft, vehicle, or mode of Transportation licensed or registered by a governmental authority with competent jurisdiction. Conveyances include, but are not limited to, air ambulances, land ambulances and private motor vehicles.

Covered Accident means an Accident that occurs directly and independently of all other causes while coverage is in effect for an Insured Person resulting in a Covered Loss under the Policy for which benefits are payable. The Insured Person must be participating in a Covered Activity, as identified in the Schedule, when the Accident occurs.

Covered Activity means those activities set out in the Covered Activities section of the Schedule, in which Insured Persons are provided insurance under the Policy.

Covered Loss means an accidental death, dismemberment or other Injury covered under the Policy.

Deductible means the amount of Usual and Customary Charges for Covered Medical Services that must be incurred by the Insured Person before benefits become payable. The amount of the Deductible is shown in the Rider Schedule. Benefits are not payable for charges applied to the Deductible.

Diagnostic Exams mean any of the following major/advanced tests: angiogram, arteriogram, bone scintigraphy, CT, EEG, EKG, EMG, MRI, PET, SPECT, or thallium stress test. This definition does not include any lab test or x-ray.

Durable Medical Equipment means equipment of a type that is designed primarily for use, and used primarily, by people who are sick (for example, a wheelchair or a hospital bed). It does not include items commonly used by people who are not sick, even if the items can be used in the Treatment of Emergency Sickness or can be used for rehabilitation or improvement of health (for example, a stationary bicycle or a spa).

Eligible Class means any group of people listed in the Description of Eligible Class(es) shown in the Schedule.

Emergency Room (ER) means a specified area within a Hospital that is designated for emergency healthcare. This area must:

1) be staffed and equipped to handle trauma;
2) be under the direct supervision of a Physician;
3) provide Treatment by Physicians and/or Medical Professionals; and
4) provide care 24 hours per day, 7 days per week.

This definition does not include an Urgent Care Facility.

Emergency Sickness means an illness or disease diagnosed by a Physician which causes a severe or acute symptom that, if not provided with immediate treatment, would reasonably be expected to result in serious deterioration of the person's health, or place his/her life in jeopardy. Emergency Sickness also includes Complications of Pregnancy.

Experimental or Investigative Treatment means 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 of those items requiring federal or other government agency approval not received at the time the services are rendered.

Geographic Area means the city, providence or region in which the service, procedure, devices, drugs, treatment or supplies are provided or a greater area, if necessary, to obtain a representation cross-section of charges for a like treatment, service, procedure, device, drug, or supply. Inside the United States, this would be based on the first three digits of the zip code.

Heart or Circulatory Malfunction means a sudden and serious malfunction of the heart or circulatory system as a result of a diagnosis of coronary thrombosis, cerebral vascular accident, myocardial infarction, and cardiac arrest. Heart or Circulatory Malfunction does not refer to conditions such as hypertension and angina.

Ongoing symptoms are not a covered beyond the 72 hours unless:
1) these symptoms first occurred within 72 hours of the Heart and/or Circulatory Malfunction; and
2) an actual malfunction of the heart or circulatory system has been subsequently diagnosed.

Home Health Care means healthcare services provided by a Home Health Care Agency in the residence of an Insured Person, including, but not limited to, counseling services, home health aide services, Hospice Care, skilled nursing care, medical social services and Therapy Services. Services must be rendered under a plan of care that is established and reviewed regularly by a Physician.

Home Health Care Agency means an appropriately licensed home health care agency which:
1) is primarily engaged in providing home health services;
2) provides services under the supervision of a Physician or Medical Professional;
3) has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
4) maintains clinical records on all patients.

Hospice Care means specialized care, medical services and emotional support for an Insured Person who is in the last stages of an advanced illness, focusing on comfort and quality of life rather than cure.

Hospice Facility means an appropriately licensed healthcare facility, or a distinct unit within a Hospital or other institution, which:
1) provides Hospice Care and related services 24 hours per day, 7 days per week;
2) is under the direct supervision of a Physician and has a Physician or Medical Professional available at all times; and
3) is not mainly a place for care of the aged/elderly, care of persons with Substance Abuse issues/disorders, care of persons with Mental and Nervous Disorders, or a hotel or similar establishment.

Confinement in a Hospice Facility must follow certification by a Physician or hospice medical director that an Insured Person is terminally ill with less than 6 months to live if the Covered Loss runs its normal course. This definition does not include a nursing home, Rehabilitation Facility, Skilled Nursing Facility or swing bed hospitals that are authorized to provide and be paid for extended care services.

Hospital means an institution which:
1) operates pursuant to law;
2) primarily and continuously provides Medical Care and treatment of sick and injured persons on an inpatient basis;
3) operates facilities for medical and surgical diagnosis and treatment by or under the supervision of a staff of legally qualified physicians; and
4) provides 24 hour a day nursing service by or under the supervision of registered graduate 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) an alcohol or drug treatment facility; or
3) a place for rest, custodial care or for the aged.

Immediate Family Member means a person who is related to the Insured Person in any of the following ways: Spouse or Partner, brother-in-law, sister-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes step-parent), grand-parent (includes step grand-parent), brother or sister (includes stepbrother or stepsister and half-brother or half-sister), or child (includes a child legally adopted or a child placed for adoption but not yet adopted), or stepchild.

Injury means bodily injury sustained by an Insured Person caused from a Covered Accident that:
1) occurs while this Policy is in force as to the Insured Person whose Injury is the basis of claim;
2) occurs while the Insured Person is participating in a Covered Activity.

See the Schedule for applicability of all benefits. All Injuries sustained by one Insured Person in any one Covered Accident, including all related conditions and recurrent symptoms of the Injuries are considered a single Injury.

Inpatient means an Insured Person who is Confined and charged by a medical facility for room and board or is being held in a Hospital for a period of 24 consecutive hours or more. The requirement that an Insured Person be charged by the medical facility does not apply to confinement in a Veteran's Administration Hospital or other Federal Government Hospital.

Insured Person means a person:
1) who is a member of an Eligible Class described in the Schedule;
2) for whom premium has been paid; and
3) while covered under this Policy.

Intensive Care Unit (ICU) means a specifically designated area of a Hospital that provides the highest level of Medical Care and:
1) is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
2) is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement;
3) is permanently equipped with special lifesaving equipment and medical apparatus for the care of the critically ill or injured;
4) is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the unit on a 24 hour basis; and
5) has a Physician assigned to the unit on a full-time basis.

An intensive care unit may include Hospital units with the following (or similar) names: burn unit; critical care unit; neonatal intensive care unit; cardiac care unit; or transplant unit.

An intensive care unit is not any of the following step-down units: intermediate care unit; modified/moderate care unit; Observation Unit; progressive care unit; or sub-acute intensive care unit.

This definition does not include a private monitored room.

Medical Care means necessary:
1) medical or surgical treatment, services and supplies;
2) hospital, nursing and ambulance services.

Each item of Medical Care must be:
1) prescribed by a Physician;
2) for the sole purpose of treating the Injury.

Medical Emergency Evacuation means, if warranted by the severity of the Insured Person's Injury or Emergency Sickness:
1) the Insured Person's immediate Transportation from the place where he or she suffers an Injury or Emergency Sickness to the nearest hospital or other medical facility where appropriate medical treatment can be obtained;
2) the Insured Person's Transportation to his or her current place of primary residence to obtain further medical treatment in a hospital or other medical facility or to recover after suffering an Injury or Emergency Sickness and being treated at a local hospital or other medical facility; or
3) both 1) and 2) above.

A Medical Emergency Evacuation also includes medical treatment, medical services and medical supplies necessarily received in connection with such Transportation.

Medically Necessary or **Medical Necessity** means a determination by the Insured Person's Physician that Treatment, service or supply provided to treat an Injury is:

1) appropriate and consistent with the diagnosis and does not exceed in scope, duration, or intensity the level of care needed to provide safe, adequate, and appropriate treatment of the Injury;
2) is commonly accepted as proper care or treatment of the Injury in accordance with the medical practices of the United States and federal guidelines;
3) can reasonably be expected to result in or contribute to the improvement of the Injury; and
4) is provided in the most conservative manner or in the least intensive setting without adversely affecting the condition of the Injury or the quality of the Medical Care provided.

The fact that a Physician may prescribe, order, recommend, or approve a treatment, service or supply does not, of itself, make the treatment, service, or supply medically necessary for the purpose of determining eligibility for coverage under the Rider.

The Medical Professional must be acting within the scope of his/her license. A Medical Professional does not include an Insured Person or any Immediate Family Member.

Medical Professional means a person who is appropriately licensed to provide Medical Care and Treatment, including a nurse practitioner (NP/APRN), physician's assistant (PA) or registered nurse (RN). The medical professional must be acting within the scope of his/her license. A medical professional does not include an Insured Person or any Immediate Family Member.

Member of the Household means a person who maintains residence at the same address as the Insured Person at the time of the Injury.

Mental and Nervous Disorders means any condition, disease or disorder listed as a mental or nervous disorder in the most recent edition of the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM), where improvement can be reasonably expected with therapy.

This definition does not include conditions, diseases or disorders related to Substance Abuse.

Observation Unit means a specified unit within a Hospital, apart from an Emergency Room (ER), where a patient can be monitored by a Physician or Medical Professional following Treatment in an ER or as an Outpatient. This area must:

1) be under the direct supervision of a Physician;
2) provide Treatment by Physicians and/or Medical Professionals; and
3) provide care 24 hours per day, 7 days per week.

Outpatient means an Insured Person who receives Treatment or services at a Hospital, Ambulatory Surgery Center (ASC), lab, medical clinic, Physician or Medical Professional's office/clinic, radiologic center or other licensed medical facility and is neither Confined nor charged for room and board.

Partner means an individual who is a partner to an Insured Person in a civil union or domestic partnership, or other relationship as recognized and allowed by applicable federal law, state law, or law of the county, city or local government in the Insured Person's jurisdiction of residence, if:

1) an Insured Person provides acceptable evidence that the requirements of the jurisdiction in which he/she resides for the establishment of the relationship have been met;
2) an Insured Person submits a written declaration of partnership signed by both parties acceptable to Us; or
3) the Insured Person and his/her partner satisfy the Policyholder's requirements for such partnerships.

Physician means a provider or practitioner who:

1) is properly licensed or certified to provide care or treatment under the laws of the state where he or she practices;
2) provides services that are within the scope of his or her license or certificate; and
3) is neither the Insured Person, a Member of the Household of the Insured Person or an Immediate Family Member.

Policy means this insurance policy, certificate, the Schedule and all attached riders, amendments, endorsements or other papers.

Policy Period means the period between the Policy Effective Date and Policy Termination Date. These dates are shown on the Schedule.

Pre-existing Condition means a health condition for which an Insured Person has sought or received medical advice or Treatment from a Physician or Medical Professional at any time during the 12 months immediately preceding the Policy Effective Date of coverage under the Policy.

Reasonable Expenses means fees and prices which do not exceed those generally charged for similar Medical Care in the local area where received by the Insured Person. For purposes of this coverage, We reserve the right to determine Reasonable Expenses. An expense is considered to be incurred on the date the Medical Care is rendered.

Rehabilitation Care Facility means an appropriately licensed healthcare facility, or a distinct unit within a Hospital or other institution, which:

1) provides Rehabilitation Care Services;
2) is under the direct supervision of a Physician;
3) has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
4) is not mainly a place for rest, Custodial Care, care of the aged/elderly, care of persons with Substance Abuse issues/disorders, care of persons with Mental and Nervous Disorders, or a hotel or similar establishment.

Confinement in a rehabilitation care facility must be at the direction of a Physician. This definition does not include a Hospice Facility, nursing home, Skilled Nursing Facility or swing bed hospitals that are authorized to provide and be paid for extended care services.

Rehabilitation Care Services means coordinated multidisciplinary physical restorative services (the combined use of medical, social, educational and vocational services) to enable an Insured Person who has experienced a disabling Covered Loss to achieve the highest possible functional ability.

Schedule means the benefits, benefit amounts, terms, limitations, and provisions of coverage selected by the Policyholder which is attached to and made a part of this Policy.

Sickness means an illness, disease or condition that impairs an Insured Person's normal functioning of mind or body and which is not the direct result of an Injury or Accident. Sickness also includes Complications of Pregnancy.

Skilled Nursing Facility means an appropriately licensed healthcare facility, or a distinct unit within a Hospital or other institution, which:

1) provides skilled nursing care and related services 24 hours per day, 7 days per week;
2) is under the direct supervision of a Physician and has a Physician or Medical Professional available at all times;
3) has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
4) is not mainly a place for rest, Custodial Care, care of the aged/elderly, care of persons with Substance Abuse issues/disorders, care of persons with Mental and Nervous Disorders, or a hotel or similar establishment.

Confinement in a Skilled Nursing Facility must be at the direction of a Physician. This definition does not include a Hospice Facility, nursing home, Rehabilitation Care Facility or swing bed hospitals that are authorized to provide and be paid for extended care services.

Spouse means any individual who is recognized as the spouse of the Insured Person, under applicable state law.

Therapy Services means acupuncture, respiratory therapy, occupational therapy, physical therapy or speech therapy.

Transportation means moving an individual by the most efficient and available land, water or air Conveyance.

Treatment means medical advice, diagnosis, care or services (including diagnostic measures) received by a person, or the use of drugs or medicines by a person.

Urgent Care Facility means a licensed, freestanding healthcare facility providing immediate, short-term Medical Care without an appointment, other than a Hospital (including any Outpatient department of a Hospital), Emergency Room, or Physician or Medical Professional's office/clinic. The facility must:

1) be under the direct supervision of a Physician; and
2) provide Treatment by Physicians and/or Medical Professionals.

Usual and Customary Charge(s) means the average amount charged by most providers for treatment, service or supplies in the Geographic Area where the treatment, service or supply is provided.

We, **Us** or **Our** means the Hartford Fire Insurance Company.

POLICY EFFECTIVE AND TERMINATION DATES

Policy Effective Date
This Policy begins on the Policy Effective Date shown in the Schedule at 12:01 AM Standard Time at the address of the Policyholder where this Policy is delivered.

Policy Termination Date
We may terminate this Policy by giving 31 days advance notice in writing to the Policyholder. Either We or the Policyholder may terminate this Policy on any premium due date by giving 31 days advance notice in writing to the other party.

This Policy may, at any time, be terminated by mutual written consent of the Policyholder and Us.

This Policy terminates automatically on the earlier of:
1) the Policy Termination Date shown in the Schedule; or
2) the end of the Grace Period if premiums are not paid when due.

Termination takes effect at 12:01 AM Standard Time at the Policyholder's address on the date of termination.

INSURED PERSON'S EFFECTIVE AND TERMINATION DATES

Insured Person's Effective Date
An Insured Person's coverage under this Policy begins on the latest of:

1) the Policy Effective Date;
2) the date for which the first premium for the Insured Person's coverage is paid; or
3) the date the person becomes a member of an Eligible Class as described in the Schedule.

A change in an Insured Person's coverage under this Policy due to a change in his or her Eligible Class or Covered Activity becomes effective on the later of:

1) when the change in his or her Eligible Class or Covered Activity occurs; or
2) if the change requires a change in premium, the date the changed premium is paid.

However, a change in coverage applies only with respect to a Covered Loss that occurs once the change becomes effective.

Insured Person's Termination Date
An Insured Person's coverage under this Policy ends on the earliest of:

1) the date this Policy is terminated (unless the Policyholder and Us agree, in writing, to permit coverage to continue to the end of the period for which premiums have been paid in lieu of a return of unearned premiums);
2) the end of the Grace Period if premiums are not paid when due; or
3) the date the Insured Person ceases to be a member of any Eligible Class described in the Schedule.

Termination of coverage will not affect a claim for a Covered Loss that occurs either before or after such termination if that loss results from a Covered Accident that occurred while the Insured Person's coverage was in force under this Policy.

PREMIUM

Premiums
Premiums are payable to Us as shown in the Schedule. We may change the required premiums due on any Policy anniversary date, as measured annually from the Policy Effective Date, by giving the Policyholder at least 31 days advance written notice.

We may change the required premiums as a condition of any renewal of this Policy. We may also change the required premiums at any time when any change affecting rates is made in this Policy. Any such change in this Policy will not take effect until any required additional premium is received by Us, except as otherwise agreed to in writing by the Policyholder and Us.

We may change the premium rates if:

1) there is a change in the Policy;
2) there is any change to state or federal law or inaction by state or federal law makers which affects Our liability under the Policy on a temporary or permanent basis;
3) Social Security Disability benefits are reduced or eliminated on a temporary or permanent basis due to the actual or threatened insolvency of the Social Security Disability Insurance Trust Fund;
4) there is a 10% increase or decrease in the number of insured;
5) the Policyholder adds or deletes a subsidiary or affiliated business entity; or
6) there has been a material misstatement in the reported experience during the pre-sale process.

Renewal
This Policy may be renewed, subject to Our consent, by payment of premiums as they become due. The renewal premiums will be based on Our rates in effect at the time of renewal.

Grace Period
A grace period of 31 days will be provided for the payment of any premium due after the Initial Premium. This Policy will not be terminated for nonpayment of premium during the Grace Period if the Policyholder pays all premiums due by the last day of the Grace Period. This Policy will terminate on the last day of the period for which all premiums have been paid if the Policyholder fails to pay all premiums due by the last day of the Grace Period.

If We expressly agree to accept late payment of a premium without terminating the Policy, the Policyholder will be liable to Us for any unpaid premiums for the time this Policy is in force.

No grace period will be provided if We receive notice to terminate this Policy prior to a premium due date.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFIT(S)

If the Insured Person's Injury results in any of the losses listed in the table below within 365 days after the date of the Covered Accident, We will pay the sum shown opposite the loss. We will not pay more than the Accidental Death or Accidental Dismemberment Principal Sum shown for each Insured Person for all losses due to the same Covered Accident subject to the Age Reduction Schedule. The Accidental Death or Accidental Dismemberment Principal Sum amount is shown in the Schedule.

FOR LOSS OF:	BENEFIT:
Life	100% of the Accidental Death Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	100% of the Accidental Dismemberment Principal Sum
One Hand and One Foot	100% of the Accidental Dismemberment Principal Sum
One Hand and Sight of One Eye	100% of the Accidental Dismemberment Principal Sum
One Foot and Sight of One Eye	100% of the Accidental Dismemberment Principal Sum
Speech and Hearing in Both Ears	100% of the Accidental Dismemberment Principal Sum
Speech and Hearing in One Ear	75% of the Accidental Dismemberment Principal Sum
One Arm or One Leg	75% of the Accidental Dismemberment Principal Sum
One Hand or One Foot	50% of the Accidental Dismemberment Principal Sum
Sight of One Eye	50% of the Accidental Dismemberment Principal Sum
Speech or Hearing in Both Ears	50% of the Accidental Dismemberment Principal Sum
Thumb and Index Finger on the Same Hand	25% of the Accidental Dismemberment Principal Sum
Hearing in One Ear	25% of the Accidental Dismemberment Principal Sum
One Thumb	10% of the Accidental Dismemberment Principal Sum

For purposes of this benefit:

1) **Loss of Arm** means Severance of an arm above the elbow joint, including the Severance of the entire arm.
2) **Loss of Both Feet, Loss of One Foot** means Severance of a foot or both feet above the ankle joint, including the Severance of an entire leg or any part of a leg that includes an entire foot.
3) **Loss of Both Hands, Loss of One Hand** means Severance of at least four whole fingers at or proximal to the metacarpophalangeal joints (the joints that connect the fingers and the hand) from one or both hands, including the Severance of an entire arm or any part of an arm that includes an entire hand.
4) **Loss of Fingers or Thumb** means Severance of more than one finger or the thumb at least at or proximal to the first interphalangeal joint of each finger.
5) **Loss of Hearing** means total and permanent loss of hearing in one or both ears which cannot be corrected by any means.
6) **Loss of Leg** means Severance of a leg above the knee joint, including the Severance of the entire leg.
7) **Loss of Sight of Both Eyes, Loss of Sight of One Eye** means total and permanent loss of sight or blindness which cannot be corrected by any means, or Severance of one or both eyes.
8) **Loss of Speech** means total and permanent loss of audible voice communication which cannot be corrected by any means.
9) **Severance** means the complete separation and dismemberment of the part from the body.

Exposure and Disappearance

We will presume an Insured Person has died due to Injuries if, while insurance is in effect, the Insured Person dies as a result of exposure to the elements as a result of an Injury.

We will presume the Insured Person has died if, while insurance is in effect and after the forced landing, stranding, sinking, or wrecking of a vehicle:

1) the Insured Person disappears; and
2) the Insured Person's body is not found within 1 year of disappearance; and
3) a valid death certificate is issued by a court of competent jurisdiction.

LIMITATIONS AND EXCLUSIONS

Economic Sanction
We will not provide coverage or pay benefits under this Policy to the extent, and only to the extent, that We are prohibited from providing coverage or making payment by any type of travel restriction, trade restriction, economic sanction, or embargo imposed by the United States government.

Age Reduction Schedule
The Principal Sum used to determine the amount payable for a Covered Loss will be reduced if an Insured Person is age 70 or older on the date of the Covered Accident with respect to any of the following Benefits provided by this Policy:

1) Accidental Death & Dismemberment Benefit;
2) Heart or Circulatory Benefit

The reduced amount will be determined by multiplying the Principal Sum by the percentage shown below for the Insured Person's attained age:

AGE ON DATE OF ACCIDENT	PERCENTAGE OF PRINCIPAL SUM
70-74	65%
75-79	45%
80-84	30%
85 and older	15%

These reductions also apply if:

1) You become covered under The Policy; or
2) Your coverage increases;

on or after the date You attain age 70.

Premium for an Insured Person age 70 or older is based on 100% of the coverage that would be in effect if the Insured Person were under age 70.

Age refers to the age of the Insured Person's most recent birthday, regardless of the actual time of birth.

Limitation on Multiple Benefits
If an Insured Person suffers one or more Covered Losses from the same Covered Accident for which amounts are payable under all of the benefits provided by this Policy, the maximum amount payable under all of the benefits combined will not exceed the largest amount payable for one of those Covered Losses.

Limitation on Multiple Covered Activities
If an Insured Person's Injury is caused by a Covered Accident that occurs while the Insured Person is participating in more than one Covered Activity, and if the same benefit applies to that Insured Person with respect to more than one such Covered Activity, then the Accidental Death or Accidental Dismemberment Principal Sum for that Insured Person for that Covered Accident will be determined as though the Covered Accident occurred while the Insured Person was participating in only one such Covered Activity. We will pay the benefits for the Covered Activity with the largest Principal Sum for that Insured Person.

Exclusions

Unless otherwise specified in the Policy, including any attached Riders, the Policy does not cover loss resulting from or for:

1) suicide or attempted suicide, whether sane or insane, or intentionally self-inflicted injury;
2) war or act of war, whether declared or undeclared;
3) injury sustained while on active duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard Service is not excluded, unless it extends beyond 31 days;
4) injury sustained while on any aircraft except a civil or public aircraft, or military transport aircraft;
5) injury sustained while on any aircraft:
   a) as a pilot, crewmember or student pilot;
   b) as a flight instructor or examiner;
   c) if it is owned, operated or leased by or on behalf of the Policyholder, or any Employer or organization covering any Eligible Class under the Policy; or
   d) being used for tests, experimental purposes, stunt flying, racing or endurance tests;
6) injury for which the Insured Person is eligible to receive Workers' Compensation benefits or similar benefits, regardless of whether he or she has applied for the benefits;
7) injury sustained while under the influence of any narcotics, drug or controlled substance, unless administered by or taken according to the instruction of a licensed Physician;
8) injury sustained as a result of the Insured Person's voluntary intoxication through the use of poison, gas or fumes, whether by ingestion, injection, inhalation or absorption;
9) injury sustained by an Insured Person during or as a result of his or her commission of a felony or while incarcerated for a felony, except that this exclusion will not be applicable upon acquittal or dismissal of the felony charges;
10) injury sustained while the Insured Person is under the influence of intoxicants (as defined by the law of the jurisdiction in which the Injury occurred);
11) sickness, disease, or bacterial or viral infection, or medical or surgical treatment thereof unless and only to the extent covered by Rider, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
12) Mental and Nervous Disorders;
13) services for which no charge is normally made; or
14) injury sustained while playing or practicing in:
   a) any inter-school club sports;
   b) any intramural sports; or

   Any sports activity that is a Covered Activity is not included in this exclusion.
15) any loss incurred while outside the United States, its Territories or Canada.

CLAIMS PROVISIONS

Notice of Claim
The person who has the right to claim benefits (the claimant, beneficiary or his or her representative) must give Us written Notice of a Claim within 30 days after a Covered Loss begins. Failure to furnish notice within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give notice within such time, provided such notice is furnished as soon as reasonably possible. The notice should include the Insured Person's name and the Policy Number. Notice should be given to Our agent or sent to Us.

Claim Forms
When We receive the notice of claim, We will send forms to the claimant for giving Us Proof of Loss. The forms will be sent within 10 days after We receive the notice of claim. If the forms are not received, the claimant will satisfy the Proof of Loss requirement if a written notice of the occurrence, character and extent of the loss is sent to Us.

Proof of Loss
Written Proof of Loss must be furnished to Us within 90 days after the date of the loss. If the loss is one for which this Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as We may reasonably require. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

All Proof of Loss submitted must be satisfactory to Us and must include information which is required by Us to adjudicate the claim. In addition, the claimant must provide Us any Proof of Loss documentation specifically required in any relevant Rider. We reserve the right to request additional information reasonably related to the claim.

Time of Payment of Claims
We will pay any benefit due, other than benefits for which the Policy provides periodic payment, immediately after We receive Proof of Loss unless we provide the Insured Person with a written itemization of any documents or other information needed to process the claim, or any portions thereof which are not being paid, within 15 days for electronic claims or within 30 days for paper claims after receipt of Proof of Loss. Subject to due written Proof of Loss, all accrued benefits for which the Policy provides periodic payment will be paid no later than at the expiration of each period of 30 days during the continuance of the period for which benefits are due, and any balance remaining unpaid at the termination of the period will be paid immediately upon receipt of Proof of Loss. We shall pay to the Insured Person or beneficiary claiming payments under the Policy, interest equal to 12 percent per annum on the proceeds or benefits due under the terms of the Policy for failure to pay such benefits within 30 days.

Payment of Claims
We will pay any benefit due for loss of life:

1) according to the written beneficiary designation on file with the Policyholder; otherwise, if no beneficiary is named or no named beneficiary survives the Insured Person, We will pay
2) to the survivors in equal shares, in the first of the following classes to have a survivor at the Insured Person's death:
    a) Spouse or Partner;
    b) children;
    c) parents;
    d) brothers and sisters.

If there is no survivor in these classes or if there are legal impediments to determining who the survivors or beneficiaries are, payment will be made to the Insured Person's estate. All other benefits due and not assigned will be paid to the Insured Person, if living. Otherwise, the benefits will be paid according to the preceding language.

If a benefit due is payable to:

1) the Insured Person's estate; or
2) the Insured Person or a beneficiary who is either a minor or not competent to give a valid release for the payment.

We may pay up to $1,000 of the benefit due to some other person whom We believe is entitled to the payment, and who is related to the Insured Person or the beneficiary by blood or marriage. We will be relieved of further responsibility to the extent of any payment made in good faith. We may pay benefits directly to any Hospital or person rendering covered

services, unless the Insured Person requests otherwise in writing. The Insured Person must make the request no later than the time he or she files Proof of Loss.

Upon receipt of due written Proof of Loss, benefit payments for charges incurred by the Insured Person for covered medical services will be made directly to the provider at Our option. If any such charges have been paid by the Insured Person, the benefit payment for those charges will be made to the Insured Person upon written proof of payment.

Appealing Denial of Claims
If a claim for benefits is wholly or partially denied, notice of the decision shall be furnished to the Insured Person. This written decision will:

1) give the specific reason or reasons for denial;
2) make specific reference to Policy provisions on which the denial is based;
3) provide a description of any additional information necessary to prepare the claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

On any denied claim, an Insured Person or his representative may appeal to Us for a full and fair review. The claimant may:

1) request a review upon written request within 60 days of receipt of claim denial;
2) review pertinent documents; and
3) submit issues and comments in writing.

We will make a decision no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after We receive the request for review. The written decision will include specific reasons for the decision on which the decision is based.

Subrogation
In the event:

1) an Insured Person suffers a Covered Loss caused, in full or in part, by the act or omission of any person or legal entity;
2) the Insured Person or claimant becomes entitled to and are paid benefits under the Policy; and
3) the Insured Person or claimant does not initiate legal action for the recovery of such benefits from a Third Party in a reasonable period of time or notify Us that he or she does not intend to do so;

then We will be subrogated to any rights such person may have against a Third Party and may, at Our option, bring legal action against or otherwise pursue a Third Party to recover any payments made by Us in connection with the Covered Loss.

Third Party, as used in this provision, means:

1) any person or legal entity whose act or omission, in full or in part, causes the Covered Loss for which benefits are paid or payable under the Policy; or
2) any insurer, including the Insured Person's own, that provides benefits to the Insured Person or claimant as a result of the act or omission which caused the Covered Loss for which benefits are paid or payable under the Policy.

This provision does not apply to Accidental Death and Dismemberment benefits.

Physical Examinations and Autopsy
We, at our own expense, shall have the right and opportunity to have:

1) a claimant for whom a claim is made examined by a Physician or Medical Professional of Our choice during the pendency of a claim as often as reasonably required; and
2) an autopsy conducted for a claimant for whom a claim is made in case of death, where not prohibited by law.

Legal Actions
No legal action may start:

1) until 60 days after Proof of Loss has been given; or
2) more than 3 years after the time Proof of Loss is required to be given, unless otherwise required by law.

Assignment

This insurance may not be assigned. The Insured Person may not assign any of his or her rights, privileges or benefits under this Policy. Benefit payments may be assigned as allowed in the Payment of Claims provision.

Workers' Compensation Coverage
The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

GENERAL PROVISIONS

Entire Contract
The entire contract between the Policyholder and Us consists of this Policy and any other papers made a part of this Policy at issue.

Incontestability
In the absence of fraud, the validity of this Policy shall not be contested, except for nonpayment of premium, after it has been in force for two years from the Policy Effective Date.

Statements
In the absence of fraud, all statements made by the Policyholder and persons insured under this Policy will be deemed representations and not warranties. No statement will be used in any contest unless it is in writing, signed by the person making it and a copy of it is given to the person who made it, or, in the event of the death or incapacity of the Insured Person, to the Insured Person's beneficiary or personal representative.

Changes
No agent has authority to change or waive any part of this Policy. To be valid, any change or waiver must be in writing, approved by one of Our officers and made part of this Policy.

Noncompliance with Policy Requirements
Any express waiver by Us of any requirements of this Policy will not constitute a continuing waiver of such requirements. Any failure by Us to insist upon compliance with any Policy provision will not operate as a waiver or amendment of that provision.

Data Furnished by Policyholder
The Policyholder must maintain adequate records acceptable to Us and provide any information required by Us relating to this insurance, its premium, and any benefits claimed or paid hereunder.

Right to Audit
We will have the right to inspect and audit, at any reasonable time, all records and procedures of the Policyholder that may have a bearing on this insurance, its premium, and any benefits claimed or paid hereunder.

Certificates
If required by the laws of the state where this Policy is delivered, We will give certificates to the Policyholder for delivery to Insured Persons. The certificates will state the features of this Policy which are important to Insured Persons.

Conformity with State and Federal Law
Any provision of the Policy that is contrary to the law of the jurisdiction in which it is delivered or with any other applicable law is amended to meet the minimum requirements of the law.

Right to Receive and Release Needed Information
We have the right to decide in Our sole judgment what facts We need to administer this Policy. We may get needed facts from, or give them to, any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Policy must give Us any facts We need to determine coverage under this Policy or determine the correct payment of a claim.

Facility of Payment and Right to Recovery
If a payment made under another plan includes an amount that should have been paid under this Policy, We may pay that amount to the organization making that payment. That amount will then be treated as though it were a benefit paid under this Policy, and We will not have to pay that amount again. If the amount of the payments made by Us is more than it should have paid under this Policy, We may recover the excess from any person(s) to or for whom We have overpaid, including insurance companies or other organizations. If benefits are overpaid, We may recover the amount overpaid by requesting a lump sum payment of the overpaid amount or reducing future benefits payable under this Policy.

New Entrants
This Policy will allow from time to time, that new eligible Insured Persons of the Policyholder be added to the Eligible Class(es) of Insured Persons originally insured under this Policy.

Misstatement of Age
If premiums for the Insured are based on age and the Insured Person has misstated his or her age, there will be a fair adjustment of premiums based on his or her true age. If the benefits for which the Insured Person is insured are based on age and the Insured Person has misstated his or her age, there will be an adjustment of said benefit based on his or her true age. We require satisfactory proof of age before paying any claim.

Clerical Error
Clerical error, whether by the Policyholder or Us, will not void the insurance of any Insured Person if that insurance would otherwise have been in effect nor extend the insurance of any Insured if that insurance would otherwise have ended or been reduced as provided in this Policy.

Policy Interpretation
We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

HARTFORD FIRE INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

THE HARTFORD

Policyholder: XXXXX
Policy Number: XXXXX

B-1 – ACCIDENTAL MEDICAL EXPENSE BENEFIT RIDER

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider.

ACCIDENT MEDICAL EXPENSE BENEFIT

If an Insured Person suffers an Injury that, within 180 days of the date of the Covered Accident that caused the Injury, requires him or her to be treated by a Physician, We will pay the Usual and Customary Charges incurred for Covered Medical Services that are Medically Necessary and received due to that Injury, up to the Maximum Amount per Insured Person for all Injuries caused by the same Covered Accident. The benefit is payable only for such charges incurred after the Aggregate Deductible has been met. Benefits are subject to the terms of the Scope of Coverage section. Benefits are then payable for charges incurred within the Maximum Benefit Period shown in the Rider Schedule.

COVERED MEDICAL SERVICES

Covered Medical Services under this Rider are as follows:

1) **Hospital:** the following services provided when the Insured Person is Confined in a Hospital:
   a) the daily room rate for a semi-private room when an Insured Person is Confined in a Hospital and general nursing care is provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.
   b) ancillary Hospital services and supplies including operating room, laboratory tests, Diagnostic Exams, anesthesia and medicines (excluding take home drugs) when Confined in a Hospital.
   c) the daily room rate when an Insured Person is Confined in a Hospital in a bed in the Intensive Care Unit; and
   d) nursing services other than private duty nursing services.
2) **Private Duty Nurse:** private duty nursing services by a registered nurse (RN) or licensed practical nurse (LPN) while an Insured Person is Confined in a Hospital. These services must be ordered by a Physician.
3) **Emergency Room:** expenses incurred within 72 hours of a Covered Accident due to Treatment in an Emergency Room. Such expenses include the attending Emergency Room Physician's charges, x-rays, laboratory procedures, medications, use of the Emergency Room, and medical supplies.
4) **Prosthesis:** artificial limbs, eyes, larynx, or other prosthesis for initial acquisition and fitting. We will not pay for repair or replacement of any prosthesis, unless due to a Covered Accident.
5) **Ambulatory Surgical Center or Ambulatory Medical Center:** Treatment including operating room, laboratory tests, anesthesia, medical supplies, and medicines (excluding take home drugs) provided in an Ambulatory Surgical Center or Ambulatory Medical Center.
6) **Physician:** expenses for Treatment provided by a Physician.
7) **Anesthesia:** expenses for pre-operative screening, anesthetics, and administration of anesthesia during a surgical procedure whether on an Inpatient or Outpatient basis.
8) **Durable Medical Equipment Rental:** expenses for rental of a wheelchair, orthopedic appliances, orthopedic braces, or other medical equipment that has therapeutic value for an Insured Person. We will not cover computers, motor vehicles, or modifications to a motor vehicle, ramps and installation costs, eyeglasses, and hearing aids. No benefits will be paid for rental charges in excess of the purchase price.
9) **Blood and Blood Products:** expenses for blood, blood products, artificial blood products, and transfusions of any blood or blood products.
10) **Ambulance:** expenses for transportation from the emergency site to the Hospital.
11) **Radiological Procedures:** Outpatient expenses for CAT Scan, MRI, X-ray, CT, PET, ultrasound, and other radiological procedures. Does not include dental x-rays.

12) **Outpatient Laboratory Tests:** expenses for laboratory tests provided when the Insured Person is not confined in a Hospital and provided by a medical facility other than an Emergency Room or Ambulatory Surgical Center.
13) **Prescription Drug:** expenses for drugs prescribed by a Physician for the Treatment of Injury and administered on an outpatient basis.
14) **Rehabilitation Care Facility:** expenses for physical and occupational rehabilitation. Treatment must be provided in a duly licensed Rehabilitation Care Facility and be under the direction of a Physician.
15) **Dental:** expenses including dental x-rays for the repair or Treatment of each injured tooth that is whole, sound, and a natural tooth at the time of the Covered Accident.
16) **Vision or Hearing Products:** eyeglasses, contact lenses, and hearing aids when damage occurs in a Covered Accident that requires medical Treatment.
17) **Skilled Nursing Facility:** expenses for Confinement in a Skilled Nursing Facility if it begins within 5 consecutive days after an Insured Person is Confined in a Hospital as a result of a Covered Accident. We will pay for Treatment if a Physician visits the Insured Person at least once every 30 days and certifies that the Confinement is Medically Necessary.
18) **Home Health Care:** expenses for Home Health Care beginning within 5 consecutive days after discharge from a Hospital, Skilled Nursing Facility, or Rehabilitation Care Facility.
19) **Expanded Sports Medical:** expenses for, or resulting from, malfunctions of the heart, embolism, heat related problems, including but not limited to, heat exhaustion, heat prostration, and heat stroke, overuse or repetitive motion injuries/symptoms, including but not limited to bursitis, tendonitis, shin splints, stress fractures, strains, and twists.
20) **Chiropractic Care:** expenses for Treatment and services received by a chiropractor.
21) **Physical and Occupational Therapy:** expenses for physical or occupational therapy and an office visit connected with any such service.
22) **Pre-Existing Condition:** expenses for Treatment or aggravation of a Pre-Existing Condition or expenses for re-Injury of a Pre-Existing Condition.

RIDER SCHEDULE

ACCIDENT MEDICAL EXPENSE

Maximum Amount per Insured Person:	XXXXX
Deductible:	XXXXX per Covered Accident
Deductible Incurral Period:	52 weeks from the date of the Covered Accident
Aggregate Deductible:	XXXXX
Coinsurance:	100% of Usual and Customary Charges
Maximum Benefit Period:	104 weeks from the date of the Covered Accident

Covered Medical Services	**Maximum Amounts Payable**
Expanded Sports Medical:	up to XXXXX per Covered Accident
Pre-existing Condition:	up to XXXXX per Covered Accident

SCOPE OF COVERAGE

Full Excess Benefits
This Rider is secondary coverage to all other policies. We will pay Usual and Customary Charges only when the Usual and Customary Charges are in excess of amounts paid or payable under any other Benefit Plan. We pay benefits without regard to any coordination of benefits provisions in any other Benefit Plan. The amount from other Benefit Plans includes any amount to which the Insured Person is entitled, whether or not a claim is made for the benefits.

Coordination with Medicare
Accident Medical Expense Benefits will be paid in compliance with the Medicare Secondary Payer Act (42 U.S.C. §1395y) and any other applicable law regulating the coordination of benefits of government health Plans. We do not intend to shift to Medicare, Medicaid or any other governmental health Plan with secondary payer status, the responsibility of primary coverage or payment for any Injury for which benefits are payable under this Rider.

AGGREGATE DEDUCTIBLE LIMITATION

The Aggregate Deductible is the amount of Covered Medical Services that must be incurred and paid by the Policyholder before Accident Medical Expense Benefits become payable under this Rider. The Aggregate Deductible amount is shown in the Rider Schedule.

Retention Amount
The Covered Medical Services applied to the Aggregate Deductible amounts are the Policyholder's Retention Amount. The Retention Amount is self-insured by the Policyholder. The Retention Amount is the amount of claims that the Policyholder must incur and pay for the Policy year.

Any portion of a claim incurred prior to the termination of the Policy that is applicable to the Retention Amount will not be affected by the termination; that portion of the claim will remain the responsibility of the Policyholder.

The Policyholder's bankruptcy, insolvency, or inability to pay the Retention Amount will not increase Our obligations under the Policy.

Legal Suit
If a claim or suit is brought against Us under the Policy, We will defend Ourselves and the Policyholder will indemnify Us up to the amount for which the Policyholder is liable under the Policy as if said action were a claim or suit brought against the Policyholder.

LIMITATIONS AND EXCLUSIONS

Rider Exclusions
Unless otherwise specified in this Rider, in addition to the exclusions in the Policy, We will not pay Accident Medical Expense Benefits for any loss, Treatment, or services resulting from, or contributed to, by:

1) pregnancy, childbirth, elective abortion, an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed;
2) Complications of Pregnancy or miscarriage, except as a result of a Covered Accident;
3) elective or cosmetic surgery, except for reconstructive surgery needed as the result of an Injury;
4) orthopedic appliances used mainly to protect an Injury, so the Insured Person can participate in a Covered Activity;
5) expenses paid or payable under any automobile insurance policy without regard to fault; (This exclusion does not apply in any state where prohibited.);
6) Treatment or service provided by a private duty nurse;
7) routine physical exams and medical services or wellness visits;
8) overuse symptoms including, but not limited to, bursitis, tendonitis, shin splints, stress fractures, heat exhaustion, heat stroke, heat prostration, malfunctions of the heart, embolism, reinjures or the aggravation thereof, sprains, hernia, strains, muscle tears, or repetitive motion Injury, and/or Treatment of Injuries that result over a period of time (such as blisters, tennis elbow, etc.), and that are a normal result of participation in a Covered Activity, except as specifically provided in the Rider;
9) expenses incurred that are in excess of Usual and Customary Charges for Covered Medical Services, or expenses that are not covered;
10) Mental and Nervous Disorders;
11) Medical Emergency Evacuation;
12) Experimental or Investigative Treatment or procedures;
13) Treatment of any condition for which the Insured Person is entitled to benefits under any Workers' Compensation Act or similar law.

Out-of-Network Limitation
In the event that an Insured Person is eligible for benefits under this Rider in excess of other medical expense coverage that is primary under a health maintenance organization, preferred provider organization, or similar health service program, a penalty will apply if the Insured Person does not use the facilities or services of the health maintenance organization, preferred provider organization or similar health service program. In such case, the benefits otherwise payable under this Rider will be reduced by 50%. This reduction shall not apply to an Insured Person in connection with any Treatment for which the health maintenance organization, preferred provider organization or similar health service program provides coverage as if the Insured Person used the facilities or services of the health maintenance organization, preferred provider organization or similar health service program. This limitation is not applicable to out-of-network Treatment provided in an emergency situation.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Covered Medical Services means the services covered by this Rider. Covered Medical Services are shown in the Rider Schedule and described in the Covered Medical Services provision.

In all other respects the Policy remains the same.

Signed for Hartford Fire Insurance Company

Kevin Barnett, *Secretary*

Douglas Elliot, *President*

HARTFORD FIRE INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

THE HARTFORD

Policyholder: XXXXX
Policy Number: XXXXX

B-28 – HEART OR CIRCULATORY BENEFIT RIDER

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to a Heart or Circulatory Malfunction that occurs on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider.

HEART OR CIRCULATORY BENEFIT

If an Insured Person suffers a Heart or Circulatory Malfunction that results in death as a direct result of participating in a Covered Activity, We will pay the Accidental Death Benefit shown in the Schedule provided that:

1) the symptom(s) of such malfunction(s) is (are) first medically treated while the Policy is in force with respect to such Insured Person and within 72 hours after such participation; and
2) such Insured Person has not, within the last 10 years prior to the date of such participation in the Covered Activity, been diagnosed with, or received any medication for any myocardial infarction, angina pectoris, coronary thrombosis or a cerebral vascular incident unless the condition for which the prescribed medication is taken remains controlled without any change in the required prescription;
3) the Insured Person is under age 65.

In all other respects the Policy remains the same.

Signed for Hartford Fire Insurance Company

Kevin Barnett, *Secretary*

Douglas Elliot, *President*