

**ACCIDENT PLAN 1**



**METROPOLITAN LIFE INSURANCE COMPANY  
NEW YORK, NEW YORK**

**Certificate Rider**

**Group Policy No.:** 5570720

**Policyholder:** Stone County School District

**Rider Effective Date:** The later of September 1, 2023 or the date that applies to the insured's Certificate as shown in the insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife.

Your Certificate is changed as follows:

The following notices are added to the Notices section of Your Certificate:

**NOTICES  
GROUP ACCIDENT INSURANCE**

**THERE MAY BE DIFFERENCES IN BENEFITS, ELIGIBILITY REQUIREMENTS, LIMITATIONS OR EXCLUSIONS THAT APPLY BASED ON STATE REQUIREMENTS FOR THE STATE IN WHICH YOU RESIDE ON THE INITIAL DATE OF YOUR COVERAGE.**

**PLEASE READ ANY NOTICE(S) THAT FOLLOW BELOW CAREFULLY. ANY SUCH NOTICE(S) PROVIDE REQUIRED DISCLOSURES AND INFORMATION ABOUT SIGNIFICANT STATE REQUIREMENTS.**

**PLEASE CONTACT US WITH QUESTIONS OR FOR ADDITIONAL INFORMATION.**

**ARKANSAS NOTICE:**

**IMPORTANT NOTICE**

**IF YOU HAVE A QUESTION CONCERNING YOUR COVERAGE OR A CLAIM, FIRST CONTACT YOUR GROUP EMPLOYER OR GROUP ACCOUNT ADMINISTRATOR. IF, AFTER DOING SO, YOU STILL HAVE A CONCERN, YOU MAY CALL METLIFE'S TOLL-FREE TELEPHONE NUMBER: 1-800-GET-MET8**

**IF YOU ARE STILL CONCERNED AFTER CONTACTING BOTH YOUR GROUP EMPLOYER AND METLIFE, YOU SHOULD FEEL FREE TO CONTACT:**

**ARKANSAS INSURANCE DEPARTMENT  
1 COMMERCE WAY, SUITE 102  
LITTLE ROCK, ARKANSAS 72202  
(800) 852-5494 or (501) 371-2640**

**YOU HAVE THE RIGHT TO FILE A COMPLAINT WITH THE ARKANSAS INSURANCE DEPARTMENT (AID).**

**YOU MAY CALL AID TO REQUEST A COMPLAINT FORM AT  
(800) 852-5494 or (501) 371-2640**

**COLORADO NOTICES:**

**THIS IS A LIMITED HEALTH BENEFIT COVERAGE POLICY AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.**

**THE LODGING BENEFIT, INCLUDED UNDER THE OTHER BENEFITS SECTION OF YOUR CERTIFICATE, IS NOT AVAILABLE FOR, AND DOES NOT APPLY TO, COLORADO RESIDENTS.**

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**CONTACT US**

If You have questions about Your insurance coverage You may contact MetLife at 1-800-GET-MET8.

MetLife Toll Free Number(s):

For Claim Information	1-800-GET-MET8
For General Information	1-800-GET-MET8

To make a complaint to MetLife, You may Write to:

Metropolitan Life Insurance Company  
Attn: Consumer Relations Department  
700 Quaker Lane, 2nd Floor  
Warwick, Rhode Island 02886

Or call MetLife at 1-800-GET MET8 or 1-800-438-6388.

**CONNECTICUT NOTICES:**

**This is an Accident only policy and it does not pay benefits for loss from Sickness.**

**This Certificate does not replace or otherwise effect any statutorily required workers' compensation insurance required to be provided to You by law.**

**COVERAGE FOR RESIDENTS OF CONNECTICUT INCLUDES THE FOLLOWING BENEFITS DESCRIBED IN THE OUTLINE OF COVERAGE:**

- **ACCIDENTAL INGESTION OUTPATIENT TREATMENT BENEFIT**
- **ACCIDENTAL INGESTION CONFINEMENT BENEFIT**
- **HOME CARE BENEFIT**

**FLORIDA NOTICE:**

**IMPORTANT NOTICE**

For information about coverage or assistance in resolving complaints  
contact Us at 1-800-GET-MET8

**IDAHO NOTICES:**

**Notice to Buyer: This is an Accident-only Certificate and it does not pay benefits for loss from Sickness. Review Your Certificate carefully.**

**Notice to Buyer: This Certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.**

**30-Day Right to Examine Certificate. Please read this Certificate carefully. If You are not satisfied for any reason, You may return this Certificate to Us within 30 days from the date You receive it. If You return it within the 30 day period, this Certificate will be void from the beginning. We will refund any premium or Contribution paid within 30 days after We receive the returned Certificate.**

You may contact the Idaho Department of Insurance at:

Idaho Department of Insurance  
Consumer Affairs  
700 W State Street, 3rd Floor  
PO Box 83720

Boise, ID 83720-0043  
1-800-721-3272 or 208-334-4250  
[www.DOI.Idaho.gov](http://www.DOI.Idaho.gov)

**NEW HAMPSHIRE NOTICES:**

**THIS IS A LIMITED CERTIFICATE – READ IT CAREFULLY**

THE ORGANIZED SPORTS ACTIVITY INJURY BENEFIT RIDER IS NOT AVAILABLE FOR, AND DOES NOT APPLY TO, NEW HAMPSHIRE RESIDENTS.

**THIS CERTIFICATE DOES NOT INSURE AGAINST LOSS RESULTING FROM SICKNESS.**

**Notice to Buyer:** This is an Accident-only Certificate and it does not pay benefits for loss from Sickness. Review this Certificate carefully. This Certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

**Notice to Buyer:** This is an ancillary health Certificate. This Certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

30-Day Right to Examine Certificate. Please read this Certificate carefully. If You are not satisfied for any reason, You may notify Us that You are cancelling Your Certificate within 30 days from the date of delivery by calling Us at the number set forth in the Certificate. If You notify Us that You are cancelling within the 30 day period, this Certificate will be void from the beginning. We will refund any premium or Contribution paid within 30 days after We receive Your notice of cancellation.

This Certificate does not provide comprehensive health insurance coverage. It is not intended to satisfy the individual mandate of the Affordable Care Act (ACA) or provide the minimum essential coverage required by the ACA (often referred to as "Major Medical Coverage"). It does not provide coverage for hospital, medical, surgical, or major medical expenses.

**Patients' Bill of Rights**

Pursuant to New Hampshire RSA 151:21, the rights and responsibilities of each patient admitted to a facility, except those admitted by a home health care provider, shall include, as a minimum, the following:

- I. The patient shall be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care and including being informed of the name, licensure status, and staff position of all those with whom the patient has contact, pursuant to RSA 151:3-b.
- II. The patient shall be fully informed of a patient's rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in writing before or at admission, except for emergency admissions. Receipt of the information must be acknowledged by the patient in writing. When a patient lacks the capacity to make informed judgments the signing must be by the person legally responsible for the patient.
- III. The patient shall be fully informed in writing in language that the patient can understand, before or at the time of admission and as necessary during the patient's stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. A statement of services that are not normally covered by Medicare or Medicaid shall also be included in this disclosure.
- IV. The patient shall be fully informed by a health care provider of his or her medical condition, health care needs, and diagnostic test results, including the manner by which such results will

- be provided and the expected time interval between testing and receiving results, unless medically inadvisable and so documented in the medical record, and shall be given the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment, and to be involved in experimental research upon the patient's written consent only. For the purposes of this paragraph "health care provider" means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing health care services, including, but not limited to, a physician, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist, and any officer, employee, or agent of such provider acting in the course and scope of employment or agency related to or supportive of health care services.
- V. The patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for the patient's welfare or that of other patients, if the facility ceases to operate, or for nonpayment for the patient's stay, except as prohibited by Title XVIII or XIX of the Social Security Act. No patient shall be involuntarily discharged from a facility because the patient becomes eligible for Medicaid as a source of payment.
- VI. The patient shall be encouraged and assisted throughout the patient's stay to exercise the patient's rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination, or reprisal.
- VII. The patient shall be permitted to manage the patient's personal financial affairs. If the patient authorizes the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with the patient's rights under this subdivision and in conformance with state law and rules.
- VIII. The patient shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion.
- IX. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.
- X. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records upon request. The charge for the copying of a patient's medical records shall not exceed \$15 for the first 30 pages or \$.50 per page, whichever is greater; provided, that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.
- XI. The patient shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by the patient, such services may be included in a plan of care and treatment.
- XII. The patient shall be free to communicate with, associate with, and meet privately with anyone, including family and resident groups, unless to do so would infringe upon the rights of other patients. The patient may send and receive unopened personal mail. The patient has the right to have regular access to the unmonitored use of a telephone.
- XIII. The patient shall be free to participate in activities of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients.
- XIV. The patient shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients.
- XV. The patient shall be entitled to privacy for visits and, if married, to share a room with his or her spouse if both are patients in the same facility and where both patients consent, unless it is medically contraindicated and so documented by a physician. The patient has the right to

- reside and receive services in the facility with reasonable accommodation of individual needs and preferences, including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.
- XVI. The patient shall not be denied appropriate care on the basis of age, sex, gender identity, sexual orientation, race, color, marital status, familial status, disability, religion, national origin, source of income, source of payment, or profession.
- XVII. The patient shall be entitled to be treated by the patient's physician of choice, subject to reasonable rules and regulations of the facility regarding the facility's credentialing process.
- XVIII. The patient shall be entitled to have the patient's parents, if a minor, or spouse, or next of kin, unmarried partner, or a personal representative chosen by the patient, if an adult, visit the facility, without restriction, if the patient is considered terminally ill by the physician responsible for the patient's care.
- XIX. The patient shall be entitled to receive representatives of approved organizations as provided in RSA 151:28.
- XX. The patient shall not be denied admission to the facility based on Medicaid as a source of payment when there is an available space in the facility.
- XXI. Subject to the terms and conditions of the patient's insurance plan, the patient shall have access to any provider in his or her insurance plan network and referral to a provider or facility within such network shall not be unreasonably withheld pursuant to RSA 420-J:8, XIV.

**NEW MEXICO NOTICES:**

**NOTICE TO CONSUMER: This is a limited benefits health plan. The benefits provided are supplemental to, and not a substitute for, major medical coverage, even in combination with other limited benefits plans. To apply for an individual or small-group major medical plan, please visit the website of the New Mexico Health Insurance Exchange at [www.bewellnm.com](http://www.bewellnm.com) or call 1-833-862-3935 (TTY: 711).**

**Consumer Complaint Notice.** If You are a resident of New Mexico, Your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If You have concerns regarding a claim, premium, or other matters relating to this coverage, You may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at: <https://www.osi.state.nm.us/Consumer Assistance/index.aspx>.

**NORTH CAROLINA NOTICES:**

**IMPORTANT CANCELLATION INFORMATION: Please read the provision titled "When Insurance Ends".**

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL:

- (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND
- (2) WILLFULLY FAIL TO DELIVER AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS, IF ANY, TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES.

VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.



**NORTH DAKOTA NOTICE(S):**

**30 Day Right to Examine Certificate:**

**Please read the Certificate carefully. If You are not satisfied for any reason, You may notify Us that You are cancelling Your Certificate within 30 days from the date of delivery by calling Us at the number set forth in the Certificate. If You notify Us that You are cancelling within the 30 day period, the Certificate will be void from the beginning. We will refund any premium or Contribution paid within 30 days after We receive Your notice of cancellation.**

**OKLAHOMA NOTICE:**

**WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.**

**SOUTH DAKOTA NOTICE(S):**

**This limited health benefits plan does not provide comprehensive medical coverage. It is a basic or limited benefits Certificate and is not intended to cover all medical expenses. This plan is not designed to cover the costs of serious or chronic illness.**

**TEXAS NOTICES:**

**THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.**

**Have a complaint or need help?**

If You have a problem with a claim or Your premium, call Your insurance company or HMO first. If You can't work out the issue, the Texas Department of Insurance may be able to help.

Even if You file a complaint with the Texas Department of Insurance, You should also file a complaint or appeal through Your insurance company or HMO. If You don't, You may lose Your right to appeal.

**Metropolitan Life Insurance Company**

To get information or file a complaint with Your insurance company or HMO:

**Call: Corporate Consumer Relations Department at 1-800-438-6388**

**Toll-free: 1-800-438-6388**

Email: [Johnstown\\_Complaint\\_Referrals@metlife.com](mailto:Johnstown_Complaint_Referrals@metlife.com)

Mail: Metropolitan Life Insurance Company  
700 Quaker Lane, 2nd Floor  
Warwick, Rhode Island 02886

**The Texas Department of Insurance**

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Email: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

**¿Tiene una queja o necesita ayuda?**

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

### **Metropolitan Life Insurance Company**

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

**Llame a: Departamento de Relaciones Corporativas del Consumidor al 1-800-438-6388**

**Teléfono gratuito: 1-800-438-6388**

Correo electrónico: [Johnstown\\_Complaint\\_Referrals@metlife.com](mailto:Johnstown_Complaint_Referrals@metlife.com)

Dirección postal: Metropolitan Life Insurance Company  
700 Quaker Lane, 2nd Floor  
Warwick, Rhode Island 02886

### **El Departamento de Seguros de Texas**

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Correo electrónico: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

**UTAH NOTICE(S):**

**THE NON-EMERGENCY CARE BENEFIT IS NOT AVAILABLE, AND DOES NOT APPLY, TO RESIDENTS OF UTAH. INSTEAD, YOU ARE ELIGIBLE FOR THE EMERGENCY CARE BENEFIT DESCRIBED IN THE OUTLINE OF COVERAGE.**

**Notice of Protection Provided by  
Utah Life and Health Insurance Guaranty Association**

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - o \$500,000 in death benefits
  - o \$200,000 in cash surrender or withdrawal values
- Health Insurance
  - o \$500,000 in hospital, medical and surgical insurance benefits
  - o \$500,000 in long-term care insurance benefits
  - o \$500,000 in disability income insurance benefits
  - o \$500,000 in other types of health insurance benefits
- Annuities
  - o \$250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 31A, Chapter 28.

**Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.**

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at [www.utlifega.org](http://www.utlifega.org) or contact:

Utah Life and Health Insurance Guaranty Assoc.  
60 East South Temple, Suite 500  
Salt Lake City UT 84111  
(801) 320-9955

Utah Insurance Department  
3110 State Office Building  
Salt Lake City UT 84114-6901  
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.

**VERMONT NOTICE:**

**THIS POLICY DOES NOT MEET THE MINIMUM COVERAGE REQUIREMENTS OF THE AFFORDABLE CARE ACT. YOU SHOULD NOT PURCHASE THIS POLICY UNLESS YOU ARE ALREADY COVERED BY COMPREHENSIVE MAJOR MEDICAL INSURANCE.**

**WASHINGTON NOTICE(S):**

**Benefits provided under this Certificate are non-coordinated - this means that benefits are payable without regard to any other coverage that You may have.**

**THE NON-EMERGENCY CARE BENEFIT IS NOT AVAILABLE, AND DOES NOT APPLY, TO RESIDENTS OF WASHINGTON. INSTEAD, YOU ARE ELIGIBLE FOR THE EMERGENCY CARE BENEFIT DESCRIBED IN THE OUTLINE OF COVERAGE.**

**WISCONSIN NOTICE:**

**KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS**

**PROBLEMS WITH YOUR INSURANCE?** - If You are having problems with Your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve Your problem.

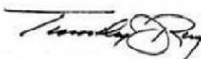
Metropolitan Life Insurance Company  
700 Quaker Lane, 2nd Floor  
Warwick, Rhode Island 02886

Toll Free Telephone: 1-800-GET-MET8

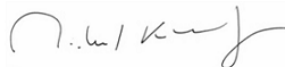
You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with the **OFFICE OF THE COMMISSIONER OF INSURANCE** at its website at <http://oci.wi.gov/> , or by contacting:

Office of the Commissioner of Insurance  
Complaints Department  
P.O. Box 7873  
Madison, WI 53707-7873  
1-800-236-8517  
608-266-0103

**This Certificate Rider is to be attached to and made a part of the Certificate.**



Timothy J. Ring  
Secretary



Michel Khalaf  
President & CEO



**METROPOLITAN LIFE INSURANCE COMPANY  
NEW YORK, NEW YORK**

**ORGANIZED SPORTS ACTIVITY INJURY BENEFIT  
CERTIFICATE RIDER**

**Group Policy No.:** 5570720

**Policyholder:** Stone County School District

**Rider Effective Date:** The later of September 1, 2023 or the date that applies to the insured's Certificate as shown in the insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife.

This Rider is added to Your Certificate of Accident Insurance.

**DEFINITIONS**

**Organized Sports Activity** means an amateur sports competition or organized practice for an amateur sports competition:

- in which participation is not for wage or profit;
- which is overseen by an Amateur Sports Organization; and
- in which formal registration is required to participate.

The term Organized Sports Activity does not include:

- coaching, officiating or refereeing activities;
- travel to or from a sports competition or practice; or
- any activities that occur before, after or between sports competitions or practices.

**Amateur Sports Organization** means an organization that oversees scholastic, recreational or social sports activities, sets up official rules and standards of play, arranges for officials to oversee competition, and organizes inter-team competition, facilities and equipment. The term includes public and private schools and sports associations.

**ORGANIZED SPORTS ACTIVITY INJURY BENEFIT**

If any of the benefits listed under Benefits Eligible for Organized Sports Activity Injury Benefit section of this Rider are payable under the Certificate for an Injury sustained by a Covered Person, We will increase the amount(s) payable under the Certificate for such benefit(s) by 25% if the following requirements are met:

- the Injury resulted from an Accident that occurred while such Covered Person was participating as a player in an Organized Sports Activity;
- We are provided with Proof of such Covered Person's registration for participation in the Organized Sports Activity; and
- We are provided with any incident report in which the Accident is reported or information that supports that the Accident occurred during an Organized Sports Activity.

## LIMITATIONS

The Organized Sports Activity Injury Benefit is only payable as an increase to a benefit that is payable under the Certificate for an Injury. If a particular benefit is not payable under the Certificate for the Injury, no increased amount will be payable under this Rider for such benefit.

## BENEFITS ELIGIBLE FOR ORGANIZED SPORTS ACTIVITY INJURY BENEFIT

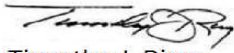
Accidental Injury Benefits

Accident – Medical Treatment and Services Benefits

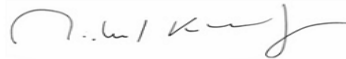
Hospital Benefits

## WHEN THIS RIDER ENDS

This Rider will end if insurance under the Certificate ends in accordance with the When Insurance Ends provision of the Certificate, however, this Rider will continue if Your insurance is continued under the Continuation of Insurance section of the Certificate.



Timothy J. Ring  
Secretary



Michel Khalaf  
President & CEO

**This Rider is to be attached to and made a part of Your Certificate.**



METROPOLITAN LIFE INSURANCE COMPANY  
NEW YORK, NEW YORK

**Certificate Rider**

**Group Policy No.:** 5570720

**Policyholder:** Stone County School District

**Rider Effective Date:** See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife

The Certificate is changed as follows:

1. The Proof of Loss provision in the Claims section of the Certificate is deleted and replaced with the following:

Proof must be provided to Us not later than 90 days after the date of the loss. If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible, but in no event, other than in the absence of the legal capacity of the claimant, later than 12 months from the date proof is otherwise required.

2. The 1st and 2nd paragraphs of the Payment of Benefits provision in the Claims section of the Certificate is deleted and replaced with the following:

When We receive the claim form and Proof We will review the claim and, if We approve it, We will pay benefits, subject to the terms and provisions of this Certificate and the Group Policy. Benefits will be paid within twenty-five (25) days after Our receipt of a clean claim submitted electronically, and will be paid within thirty-five (35) days after Our receipt of a clean claim submitted in paper format, subject to the terms and provisions of this Certificate and the Group Policy. For purposes of this provision, a "clean claim" means a claim for benefits under the Certificate that requires no further information, adjustment or alteration by You or by a Physician in order for Us to process and pay it. A clean claim does not include:

- claims which are submitted fraudulently or that are based upon material misrepresentations; and
- claims that require information essential to Us to administer pre-existing condition provisions.

Errors attributable to Us, such as system errors, do not change the clean claim status.

If We do not deny payment of benefits under this Certificate by the end of the respective 25 day or 35 day period for clean claims, and such benefits remain due and payable to You, interest will accrue on the amount of such benefits at the rate of 3 percent per month until such benefits are finally settled. If We do not pay such benefits to You when due and payable, You may bring action to recover such benefits and any interest which has accrued with respect to such benefits and any other damages which may be allowed by law. Under Mississippi law, in the event that a determination is made that a failure to pay benefits constitutes bad faith, as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, You may be entitled to recover damages in an amount up to three (3) times the amount of the benefits that remain unpaid.

**This Certificate Rider is part of Your Certificate. Please keep it with Your Certificate.**





**METROPOLITAN LIFE INSURANCE COMPANY  
NEW YORK, NEW YORK**

**CERTIFICATE OF ACCIDENT INSURANCE**

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You and Your Dependents are insured for the benefits described in this Certificate, subject to the provisions of this Certificate. References to coverage for Your Dependents throughout this Certificate only apply if insurance is in effect for Your Dependents. Please refer to the Covered Person Specifications page and Eligibility Provisions: Dependent Insurance section for details.

This Certificate is issued to You under the Group Policy. This Certificate includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.** The Group Policy is a contract between MetLife and the Group Policyholder. It may be changed or ended without Your consent or notice to You.

Group Policyholder: Stone County School District  
Group Policy Number: 5570720  
MetLife Toll Free Number: 1-800-GETMET8

**Important Notice: The insurance evidenced by this Certificate provides limited benefits. Subject to its terms, conditions and limitations, this Certificate provides benefits for Accidental death and Accidental Injuries. The benefit amounts are shown in the Schedule and are not based on any medical expenses that are incurred. You should have medical coverage in force when You enroll for this insurance.**

**This is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with Your taxes.**

**30-Day Right to Examine Certificate. Please read this Certificate carefully. If You are not satisfied for any reason, You may notify Us that You are cancelling Your Certificate within 30 days from the date of delivery by calling Us at 1-800-GETMET8. If You notify Us that You are cancelling within the 30 day period, this Certificate will be void from the beginning. We will refund any premium or Contribution paid within 30 days after We receive Your notice of cancellation.**

**Maryland Residents: The Group Policy providing coverage under this Certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.**

**WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.**

## **NOTICE FOR RESIDENTS OF MAINE**

If You were a resident of Maine on Your Certificate effective date, this notice applies to You.

You have the right to designate a third party to receive notice if Your insurance is in danger of lapsing due to a default on Your part, such as non-payment of a Contribution that is due. You may make this designation by completing a "Third Party Notice Request Form" and sending it to MetLife. Once You have made a designation, You may cancel or change it by filling out a new Third Party Notice Request Form and sending it to MetLife. The designation will be effective as of the date MetLife receives the form. Call MetLife at the toll-free telephone number shown on the face page of this Certificate to obtain a Third Party Notice Request Form.

Within 90 days after cancellation of coverage for nonpayment of premium, You, any person authorized to act on Your behalf, or any covered Dependent may request reinstatement of the Certificate on the basis that You suffered from cognitive impairment or functional incapacity at the time of cancellation.

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## COVERED PERSON SPECIFICATIONS

Certificate Effective Date:	The later of September 1, 2023 or the date that applies to the insured's Certificate as shown in the insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife
Group Policyholder: Group Policy Number:	Stone County School District 5570720
MetLife Contact Information:	1-800-GETMET8
Your Name:	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife
Your Certificate Number:	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife
Coverage for Your Dependents	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife

This Covered Person Specifications page is part of Your Certificate. Please keep it with Your Certificate.

## SCHEDULE OF INSURANCE

**IMPORTANT NOTE: Payment of the benefits listed in this Schedule is subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate. PLEASE READ THE ENTIRE CERTIFICATE CAREFULLY.**

The listing of benefits for Dependents only applies if insurance is in effect for Your Dependents under this Certificate. Please refer to the Covered Person Specifications page and the Eligibility Provisions: Dependent Insurance section of this Certificate for details.

<b>BASIC ACCIDENTAL DEATH BENEFIT: *</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
	\$75,000	\$37,500	\$15,000
<b>ACCIDENTAL DEATH – COMMON CARRIER BENEFIT: *</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
	\$225,000	\$112,500	\$45,000

\*The benefit amount will be reduced by the amount of any Accidental Dismemberment/Functional Loss/Paralysis Benefits and Modification Benefit paid for Injuries sustained by the Covered Person in the same Accident for which the Accidental Death Benefit is being paid.

### ACCIDENTAL DISMEMBERMENT/FUNCTIONAL LOSS/PARALYSIS BENEFITS:

<b>Basic Dismemberment/Functional Loss Benefit:</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
<b>Basic Dismemberment Benefit:</b>			
Loss of one finger or one toe	\$1,250	\$1,250	\$1,250
Loss of one arm or one leg	\$20,000	\$20,000	\$20,000
Loss of one hand or one foot	\$20,000	\$20,000	\$20,000
Loss of two or more fingers or toes in any combination	\$2,500	\$2,500	\$2,500
<b>Basic Functional Loss Benefit:</b>			
Loss of sight in one eye	\$20,000	\$20,000	\$20,000
Loss of hearing in one ear	\$20,000	\$20,000	\$20,000
<b>Catastrophic Dismemberment/Functional Loss Benefit:</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
<b>Catastrophic Dismemberment Benefit:</b>			
Loss of both arms or both legs or one arm and one leg	\$60,000	\$60,000	\$60,000
Loss of both hands or both feet or one hand and one foot	\$60,000	\$60,000	\$60,000
<b>Catastrophic Functional Loss Benefit:</b>			
Loss of sight in both eyes	\$60,000	\$60,000	\$60,000
Loss of hearing in both ears	\$60,000	\$60,000	\$60,000
Loss of ability to speak	\$60,000	\$60,000	\$60,000

## SCHEDULE OF INSURANCE (Continued)

<b>Paralysis Benefit:</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
Two limbs (paraplegia or hemiplegia)	\$30,000	\$30,000	\$30,000
Four limbs (quadriplegia)	\$60,000	\$60,000	\$60,000

### ACCIDENTAL INJURY BENEFITS:

<b>Fracture Benefit*</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
<b>Fracture Benefit For Closed Reduction:</b>			
Face or Nose (except mandible or maxilla)	\$2,500	\$2,500	\$2,500
Skull fracture – depressed (except bones of face or nose)	\$6,000	\$6,000	\$6,000
Skull fracture – non-depressed (except bones of face or nose)	\$3,000	\$3,000	\$3,000
Lower Jaw, Mandible (except alveolar process)	\$1,500	\$1,500	\$1,500
Upper Jaw, Maxilla (except alveolar process)	\$2,500	\$2,500	\$2,500
Upper Arm between Elbow and Shoulder (humerus)	\$2,500	\$2,500	\$2,500
Shoulder Blade (scapula), Collarbone (clavicle, sternum)	\$1,500	\$1,500	\$1,500
Forearm (radius and/or ulna), Hand, Wrist (except fingers)	\$1,500	\$1,500	\$1,500
Rib	\$1,500	\$1,500	\$1,500
Finger, Toe	\$250	\$250	\$250
Vertebrae, Body of (excluding vertebral processes)	\$2,500	\$2,500	\$2,500
Vertebral Processes	\$1,000	\$1,000	\$1,000
Pelvis (includes ilium, ischium, pubis, acetabulum except coccyx)	\$2,500	\$2,500	\$2,500
Hip, Thigh (femur)	\$6,000	\$6,000	\$6,000
Coccyx	\$1,000	\$1,000	\$1,000
Leg (tibia and/or fibula)	\$2,500	\$2,500	\$2,500
Kneecap (patella)	\$1,000	\$1,000	\$1,000
Ankle	\$1,000	\$1,000	\$1,000
Foot (except toes)	\$1,000	\$1,000	\$1,000

## SCHEDULE OF INSURANCE (Continued)

	For You	For Your Spouse	For Your Dependent Child(ren)
<b>Fracture Benefit For Open Reduction:</b>			
Face or Nose (except mandible or maxilla)	\$5,000	\$5,000	\$5,000
Skull fracture – depressed (except bones of face or nose)	\$12,000	\$12,000	\$12,000
Skull fracture – non-depressed (except bones of face or nose)	\$6,000	\$6,000	\$6,000
Lower Jaw, Mandible (except alveolar process)	\$3,000	\$3,000	\$3,000
Upper Jaw, Maxilla (except alveolar process)	\$5,000	\$5,000	\$5,000
Upper Arm between Elbow and Shoulder (humerus)	\$5,000	\$5,000	\$5,000
Shoulder Blade (scapula), Collarbone (clavicle, sternum)	\$3,000	\$3,000	\$3,000
Forearm (radius and/or ulna), Hand, Wrist (except fingers)	\$3,000	\$3,000	\$3,000
Rib	\$3,000	\$3,000	\$3,000
Finger, Toe	\$500	\$500	\$500
Vertebrae, Body of (excluding vertebral processes)	\$5,000	\$5,000	\$5,000
Vertebral Processes	\$2,000	\$2,000	\$2,000
Pelvis (includes ilium, ischium, pubis, acetabulum except coccyx)	\$5,000	\$5,000	\$5,000
Hip, Thigh (femur)	\$12,000	\$12,000	\$12,000
Coccyx	\$2,000	\$2,000	\$2,000
Leg (tibia and/or fibula)	\$5,000	\$5,000	\$5,000
Kneecap (patella)	\$2,000	\$2,000	\$2,000
Ankle	\$2,000	\$2,000	\$2,000
Foot (except toes)	\$2,000	\$2,000	\$2,000

\*Chip Fracture Benefit for any of the above: Benefit is 25% of the applicable benefit for the bone involved.

<b>Dislocation Benefit*</b>	For You	For Your Spouse	For Your Dependent Child(ren)
<b>Full Dislocation Benefit for Closed Reduction:</b>			
Lower Jaw	\$1,500	\$1,500	\$1,500
Collarbone (sternoclavicular)	\$2,000	\$2,000	\$2,000
Collarbone (acromioclavicular and separation)	\$1,500	\$1,500	\$1,500
Shoulder (glenohumeral)	\$1,500	\$1,500	\$1,500
Rib	\$1,500	\$1,500	\$1,500
Elbow	\$1,500	\$1,500	\$1,500
Wrist	\$1,500	\$1,500	\$1,500
Bone or Bones of the Hand (other than fingers)	\$1,500	\$1,500	\$1,500
Hip	\$6,000	\$6,000	\$6,000
Knee (except patella)	\$3,000	\$3,000	\$3,000
Ankle - Bone or Bones of the Foot (other than toes)	\$1,500	\$1,500	\$1,500
One Toe or Finger	\$250	\$250	\$250
	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
<b>Full Dislocation Benefit for Open Reduction:</b>			
Lower Jaw	\$3,000	\$3,000	\$3,000



## SCHEDULE OF INSURANCE (Continued)

Collarbone (sternoclavicular)	\$4,000	\$4,000	\$4,000
Collarbone (acromioclavicular and separation)	\$3,000	\$3,000	\$3,000
Shoulder (glenohumeral)	\$3,000	\$3,000	\$3,000
Rib	\$3,000	\$3,000	\$3,000
Elbow	\$3,000	\$3,000	\$3,000
Wrist	\$3,000	\$3,000	\$3,000
Bone or Bones of the Hand (other than fingers)	\$3,000	\$3,000	\$3,000
Hip	\$12,000	\$12,000	\$12,000
Knee (except patella)	\$6,000	\$6,000	\$6,000
Ankle - Bone or Bones of the Foot (other than toes)	\$3,000	\$3,000	\$3,000
One Toe or Finger	\$500	\$500	\$500

\***Partial Dislocation Benefit** for any of the above: Benefit is 25% of the applicable benefit for joint involved.

<b>Burn Benefit: Benefit for 2<sup>nd</sup> Degree Burn Percentage of total surface skin area that is burnt</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
Less than 10%	\$150	\$150	\$150
At least 10% but less than 25%	\$300	\$300	\$300
At least 25% but less than 35%	\$1,000	\$1,000	\$1,000
35% or more	\$2,000	\$2,000	\$2,000
<b>Burn Benefit: Benefit for 3<sup>rd</sup> Degree Burn Percentage of total surface skin area that is burnt</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
Less than 10%	\$2,000	\$2,000	\$2,000
At least 10% but less than 25%	\$3,000	\$3,000	\$3,000
At least 25% but less than 35%	\$10,000	\$10,000	\$10,000
35% or more	\$17,500	\$17,500	\$17,500
<b>Concussion Benefit</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
	\$750	\$750	\$750
<b>Coma Benefit</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
	\$15,000	\$15,000	\$15,000
<b>Laceration Benefit:</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
Repaired without stitches	\$100	\$100	\$100
Repaired with stitches			
Total of all lacerations is less than two inches (5.08 cm) long	\$175	\$175	\$175
Total of all lacerations is two to six inches (5.08 to 15.24 cm) long	\$400	\$400	\$400
Total of all lacerations is over six inches (over 15.24 cm) long	\$800	\$800	\$800

## SCHEDULE OF INSURANCE (Continued)

<b>Broken Tooth Benefit:</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
Crown	\$400	\$400	\$400
Extraction	\$200	\$200	\$200
Filling	\$75	\$75	\$75
<b>Eye Injury Benefit</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
	\$500	\$500	\$500
<b>ACCIDENT - MEDICAL TREATMENT AND SERVICES BENEFITS</b>			
<b>Air Ambulance Benefit</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
	\$1,500	\$1,500	\$1,500
<b>Ground Ambulance Benefit</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
	\$500	\$500	\$500
<b>Emergency Care Benefit</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
Emergency Room	\$250	\$250	\$250
Physician's Office	\$125	\$125	\$125
Urgent Care	\$125	\$125	\$125
<b>Non-Emergency Initial Care Benefit</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
	\$125	\$125	\$125
<b>Medical Testing Benefit</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
	\$250	\$250	\$250

## SCHEDULE OF INSURANCE (Continued)

	For You	For Your Spouse	For Your Dependent Child(ren)
<b>Physician Follow-Up Visit Benefit</b>			
	\$125	\$125	\$125
<b>Transportation Benefit</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
	\$500	\$500	\$500
<b>Therapy Services Benefit:</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
Cognitive behavioral therapy	\$65	\$65	\$65
Occupational therapy	\$65	\$65	\$65
Physical therapy	\$65	\$65	\$65
Respiratory therapy	\$65	\$65	\$65
Speech therapy	\$65	\$65	\$65
Vocational therapy	\$65	\$65	\$65
Acupuncture	\$65	\$65	\$65
Chiropractic therapy	\$65	\$65	\$65
<b>Pain Management Benefit (for Epidural Anesthesia)</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
	\$125	\$125	\$125
<b>Prosthetic Device Benefit</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
One device only	\$1,250	\$1,250	\$1,250
More than one device	\$2,500	\$2,500	\$2,500
<b>Medical Appliance Benefit:</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
Brace	\$200	\$200	\$200
Cane	\$200	\$200	\$200
Crutches	\$200	\$200	\$200
Walker – expected use less than 1 year	\$250	\$250	\$250
Walker – expected use 1 year or longer	\$500	\$500	\$500
Walking boot	\$200	\$200	\$200
Wheel chair or motorized scooter – expected use less than 1 year	\$400	\$400	\$400
Wheel chair or motorized scooter – expected use 1 year or longer	\$1,250	\$1,250	\$1,250
Other medical device used for mobility	\$200	\$200	\$200
<b>Medical Appliance Benefit Limit:</b>	\$1,250	\$1,250	\$1,250
Limit for all Medical Appliances combined, per Covered Person, per Accident			
<b>Modification Benefit</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
	\$2,000	\$2,000	\$2,000
<b>Blood/Plasma/Platelets Benefit</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent</b>

\$600

\$600

**Child(ren)**  
\$600

## SCHEDULE OF INSURANCE (Continued)

<b>Surgery Benefits:</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
<b>Surgical Repair Benefit:</b>			
Cranial	\$2,500	\$2,500	\$2,500
Hernia	\$250	\$250	\$250
Ruptured Disc	\$2,000	\$2,000	\$2,000
Skin Graft Benefit (only payable for a burn for which the Burn Benefit was paid)	50% of the Burn Benefit that was paid	50% of the Burn Benefit that was paid	50% of the Burn Benefit that was paid
Torn cartilage in knee	\$2,000	\$2,000	\$2,000
Torn, ruptured or severed tendon/ligament/rotator cuff			
One tendon/ligament/rotator cuff	\$1,500	\$1,500	\$1,500
Two or more tendons/ligaments/rotator cuffs	\$2,500	\$2,500	\$2,500
Thoracic cavity or abdominal pelvic cavity	\$2,500	\$2,500	\$2,500
<b>Exploratory Surgery Benefit</b> for any of the procedures listed above	\$300	\$300	\$300
<b>Other Outpatient Surgery Benefit</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
	\$500	\$500	\$500
<b>ACCIDENT - HOSPITAL BENEFITS</b>			
<b>Admission Benefit (for the day of admission)</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
	\$2,000	\$2,000	\$2,000
<b>ICU Supplemental Admission Benefit (for the day of admission)</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
	\$2,000	\$2,000	\$2,000

## SCHEDULE OF INSURANCE (Continued)

<b>Confinement Benefit</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
	\$400 per day	\$400 per day	\$400 per day
<b>ICU Supplemental Confinement Benefit</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
	\$400 per day	\$400 per day	\$400 per day
<b>Inpatient Rehabilitation Benefit</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
	\$300 per day	\$300 per day	\$300 per day
<b>OTHER BENEFITS</b>			
<b>Health Screening Benefit</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
	\$50	\$50	\$50
<b>Lodging Benefit</b>	<b>For You</b>	<b>For Your Spouse</b>	<b>For Your Dependent Child(ren)</b>
	\$300 per day	\$300 per day	\$300 per day

## DEFINITIONS

As used in this Certificate, the terms listed below will have the meanings set forth below. Other terms may be defined where they are used. When defined terms are used in this Certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

**Accident** means an act or event which:

- is unforeseen, unexpected and unanticipated;
- is definite as to time and place;
- is not a Sickness; and
- occurs while insurance is in effect under this Certificate.

The term Accident includes unavoidable exposure to the elements if such exposure was a direct result of an Accident.

**Accidental** or **Accidentally** means happening by Accident.

**Actively at Work or Active Work** means that You are performing all of the usual and customary duties of Your job on a Full-Time basis. This must be done at:

- the Group Policyholder's place of business;
- an alternate place approved by the Group Policyholder; or
- a place to which the Group Policyholder's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Group Policyholder approved vacations, holidays or temporary business closures if You were Actively at Work on the last scheduled work day preceding such time off.

**Certificate** means this Certificate including any riders attached to it.

**Coma** means a continuous state of profound unconsciousness lasting for a period of 14 or more consecutive days, characterized by the absence of purposeful response to commands, including:

- eye opening;
- verbal response; and
- motor response.

**Confined or Confinement** means the assignment to a bed as a resident inpatient in a Hospital (including an Intensive Care Unit of a Hospital) on the advice of a Physician or confinement in an observation area within a Hospital for a period of no less than 20 continuous hours on the advice of a Physician.

**Contribution** means the amount You must pay towards the total premium charged by Us for insurance under this Certificate.

**Covered Person** means You and, if insured under the Group Policy for the insurance described in this Certificate, Your Dependents.

**Covered Surgery** means any of the following procedures:

- cranial Surgery;
- skin graft to treat a burn for which the Burn Benefit was paid;
- Surgery to treat a hernia;
- thoracic cavity and abdominal pelvic cavity Surgery;
- Surgery to treat a Ruptured Disc;
- Surgery to treat torn cartilage in the knee (meniscus); or
- Surgery to treat a torn, ruptured or severed tendon, ligament or rotator cuff.

## DEFINITIONS (Continued)

**Dependent** means Your Spouse, and/or Dependent Child. No person can be insured for Accident Insurance under the Group Policy as both an employee and a Dependent.

**Dependent Child** means the following:

- Your biological child, while such child is younger than the Dependent Child Age Limit;
- Your adopted child, while such child is younger than the Dependent Child Age Limit;
- Your stepchild, while such child is younger than the Dependent Child Age Limit;
- any other child while such child is under the Dependent Child Age Limit as follows: (a) a child for whom You or Your Spouse are a legal guardian, (b) Your or Your Spouse's foster child, (c) a child for whom You or Your Spouse are chiefly responsible to provide support, (d) a child who resides with You as a regular member of Your household, (e) a child for whom You or Your Spouse are legally required to provide insurance, or (f) a child who was able to be claimed by You or Your Spouse as a dependent for Federal Income Tax purposes. Any other child also includes a grandchild who: (a) was able to be claimed by You or Your Spouse as a dependent for Federal Income Tax purposes, (b) resides with You, (c) is in Your or Your Spouse's custody, (d) is supported by You or Your Spouse, or (e) is a child of Your Dependent Child while the Dependent Child is under the Dependent Child Age Limit; or
- a Dependent Child who is a disabled child and whose age exceeds the Dependent Child Age Limit on the Certificate Effective Date who: (a) has been diagnosed with a developmental disability, mental illness or disorder, or physical disability, (b) is incapable of self-sustaining employment, and (c) is chiefly dependent on You or Your Spouse for support and maintenance. Coverage for a disabled child will take effect in accordance with the Eligibility Provisions: Dependent Insurance section of Your Certificate without regard to whether such child is under a Medical Restriction.

The term Dependent Child does not mean an unborn or stillborn child.

A person cannot be insured for Accident Insurance as a Dependent Child of more than one employee under the Group Policy.

**Dependent Child Age Limit** means:

- the end of the calendar month in which the Dependent Child reaches age 26.

**Dependent Insurance** means insurance under this Certificate for Your Dependents.

**Emergency Room** means an area within a Hospital that is dedicated to the provision of emergency care. This area must:

- be staffed and equipped to handle trauma;
- be supervised and provide treatment by Physicians; and
- provide care seven days per week, 24 hours per day.



## DEFINITIONS (Continued)

**Full-Time** means Active Work on the Group Policyholder's regular work schedule for the class of employees to which You belong. The work schedule must be at least 20 hours per week.

**Group Policy** means the policy of insurance issued by Us to the Group Policyholder under which this Certificate is issued.

**Group Policyholder** means Stone County School District.

**Hospital** means a short-term, acute care, general facility which:

- is primarily engaged in providing, by or under the continuous supervision of Physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine;
- has facilities for major Surgery either on its premises or through contractual arrangement with another Hospital;
- has a requirement that every patient must be under the care of a Physician or dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- is duly licensed by the agency responsible for licensing such Hospitals; and
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitative care.

**Injury** means any bodily harm:

- that results directly from an Accident; and
- is not specifically excluded as set forth in the section titled Accident - Exclusions.

**Intensive Care Unit or ICU** means a place which:

- is a specifically dedicated area of a Hospital that is restricted to patients who are critically ill or injured and who require intensive, comprehensive monitoring and care;
- is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement;
- is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- is under close observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24 hour basis; and
- has a Physician assigned to the intensive care unit on a full-time basis.

The term Intensive Care Unit includes Hospital units with the following names: Intensive Care Unit; Coronary Care Unit; Neonatal Intensive Care Unit; Pulmonary Care Unit; Burn Unit; or Transplant Unit.

**Medical Restriction** means a person is:

- restricted to the person's home under a Physician's care;
- receiving or applying to receive disability benefits from any source;
- an inpatient in a Hospital;
- receiving care in a hospice facility, an intermediate care facility or a long-term care facility; or
- receiving chemotherapy, radiation therapy or dialysis.

## DEFINITIONS (Continued)

**Other Outpatient Surgery** means Surgery performed on an outpatient basis, other than a Surgery for which the Surgery Benefit is payable.

**Outpatient Surgery Facility** means a facility mainly engaged in performing outpatient Surgery. It must:

- be accredited as an ambulatory surgery facility by either the Joint Commission or the Accreditation Association for Ambulatory Care;
- be approved as an ambulatory Surgery facility by Medicare; or
- meet all of the following criteria:
  - maintains all appropriate licensing for a facility that provides ambulatory Surgery;
  - is staffed by Physicians and nurses, under the supervision of a Physician;
  - has permanent operating and recovery rooms;
  - is staffed and equipped to provide emergency care; and
  - has written back-up arrangements with a local Hospital for emergency care.

**Physician** means:

- a person licensed to practice medicine and prescribe and administer drugs or to perform Surgery in the jurisdiction where such services are performed; or
- a medical practitioner who is licensed to provide a service for which a benefit is payable under this Certificate, according to the laws and regulations of the jurisdiction where such service is performed, and who is acting within the scope of such license.

The term Physician does not include:

- You;
- Your Spouse or anyone to whom You are related by blood or marriage;
- anyone with whom You are residing;
- Your adopted or stepchild;
- anyone with whom You share a business interest; or
- Your employee.

**Primary Residence** means the dwelling where a person lives for the majority of the time, whether the person owns or rents the dwelling.

**Proof** means Written evidence satisfactory to Us that a claimant has satisfied the conditions and requirements for any benefit described in this Certificate. When a claim is made for any benefit described in this Certificate, Proof must establish:

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Except as provided in the Examinations provision of this Certificate, Proof must be provided at the claimant's expense.

## DEFINITIONS (Continued)

**Rehabilitation Facility** means a facility that:

- provides rehabilitation care services on an inpatient basis; and
- maintains all required licenses and certifications.

Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by an Injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Physicians.

The term Rehabilitation Facility does not include:

- a nursing home;
- an extended care facility, unless the Covered Person is receiving rehabilitation care services on an inpatient basis at the extended care facility;
- a Skilled Nursing Facility, unless the Covered Person is receiving rehabilitation care services on an inpatient basis at the facility;
- a rest home or home for the aged;
- a hospice care facility;
- a place for alcoholics or drug addicts; or
- an assisted living facility.

**Ruptured Disc** means a tear in the spinal disc capsule. It does not include a bulging disc.

**Schedule** means the Schedule of Insurance that appears in this Certificate, and the Covered Person Specifications page.

**Sickness** means:

- a physical illness, physical infirmity or physical disease;
- pregnancy; or
- infection, but not an infection received through an Accidental cut or wound.

**Signed** means any symbol or method executed or adopted by a person with the present intention to authenticate a record. The signature may be transmitted by paper or electronic media, provided it is consistent with applicable law.

**Skilled Nursing Facility** means a facility that provides skilled, intermediate or custodial care that meets all of the following requirements:

- if licensing or certification is required, maintains all appropriate licensing or certification under the laws where it is located as a skilled or intermediate nursing facility;
- has 24 hour a day nursing care provided by any of the following who is licensed under the laws where the services are performed: a registered professional nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.);
- has 24 hour a day care performed by an awake, and trained or certified staff supervised by a nurse who is an R.N, L.P.N. or L.V.N.;
- keeps a Written record of services performed for each client;
- has established procedures to obtain emergency medical care; and
- services are not limited to provision of food, shelter, and other residential services such as laundry.

**Spouse** means Your lawful spouse.

## DEFINITIONS (Continued)

**Surgery** means a procedure performed by a Physician involving an incision of the Covered Person's skin or tissue that, in and of itself, is intended to be curative, palliative or exploratory.

**Urgent Care Facility** means a health care facility:

- that is separate from a Hospital or a separate unit within a Hospital; and
- the primary purpose of which is the offering and provision of immediate, short-term medical care, for urgent care.

**United States** means the United States of America, its territories and its possessions.

**We, Us** and **Our** mean Metropolitan Life Insurance Company.

**Write, Written** or **Writing** means a record that may be transmitted by paper or electronic media, and that is consistent with applicable law.

**You** and **Your** means an employee who is insured under the Group Policy for the insurance described in this Certificate.

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOU**

### **ELIGIBLE CLASS**

#### **CLASS 1**

All Active Full-Time Employees

### **DATE YOU ARE ELIGIBLE FOR INSURANCE**

You may only become eligible for the Accident Insurance available for Your eligible class.

If You are in an eligible class on the date insurance becomes available for the class, You will be eligible for insurance on the date You complete any applicable eligibility waiting period set by the Group Policyholder.

If you enter an eligible class after the date insurance becomes available to members of that class, You will be eligible for insurance on the date You complete any applicable eligibility waiting period set by the Group Policyholder.

### **ENROLLMENT PROCESS**

If You are eligible for insurance, You may enroll for such insurance by completing the required form. You must also provide Written permission to deduct Contributions from Your pay for such insurance, if You are required to make such Contributions.

### **DATE YOUR INSURANCE TAKES EFFECT**

Provided that You are Actively at Work in an eligible class, insurance under this Certificate will take effect for You on the Certificate effective date. If You are not Actively at Work in an eligible class on the date insurance would otherwise take effect, insurance will take effect on the date You return to Active Work in an eligible class.

### **BENEFIT CHANGES**

Once Your insurance takes effect, You may only change Your benefits in accordance with the options available through the Group Policyholder. Please contact Us or the Group Policyholder for more information.

If You are not Actively at Work in an eligible class on the date an increase in benefits would otherwise take effect, the increase will not take effect until You return to Active Work in a class that is eligible for the increase.

## **ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE**

### **ELIGIBLE CLASS FOR DEPENDENT INSURANCE**

All Class 1 employees of the Group Policyholder as specified in the Eligibility Provisions: Insurance For You section of this Certificate are eligible for Dependent Insurance.

### **DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE**

If You are in a class of employees who are eligible for Dependent Insurance on the date Your insurance takes effect, You will be eligible for Dependent Insurance on the later of the following:

- the date Your insurance takes effect; and
- the date an individual becomes Your first Dependent.

If You enter a class of employees who are eligible for Dependent Insurance after the date Your insurance takes effect, You will be eligible for Dependent Insurance on the later of the following:

- the date You enter a class eligible for Dependent Insurance; and
- the date an individual becomes Your first Dependent.

### **ENROLLMENT PROCESS**

If You become eligible for Dependent Insurance, You may enroll for such insurance by providing Us with any information We require for each Dependent to be insured. You must also provide Written permission to deduct Contributions from Your pay for Dependent Insurance, if You are required to make such Contributions.

### **DATE DEPENDENT INSURANCE TAKES EFFECT**

#### **Newborn Children**

A Dependent Child born to You while insurance is in effect under the Certificate will be covered:

- from the moment of birth and does not need to be enrolled if Dependent Insurance is already in effect for at least one other Dependent Child; or
- for 60 days from the moment of birth if Dependent Insurance is not already in effect for at least one other Dependent Child. To continue coverage beyond the first 60 days You must notify Us of the child's birth and give Written permission to deduct Contributions from Your pay for Dependent Insurance for the newborn child.

The effective date of insurance for a newborn child will be determined without regard to whether the child is under a Medical Restriction.

## **ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE (Continued)**

### **Adopted Children**

A Dependent Child adopted by You or Placed for Adoption with You while insurance is in effect under the Certificate will be covered:

- from the moment of birth if Placement for Adoption or adoption occurs within 60 days after the child's birth; or
- from the date of adoption or Placement for Adoption if the child is adopted by You or Placed for Adoption with You more than 60 days after the child's birth.

The child does not need to be enrolled if Dependent Coverage is already in effect for at least one other Dependent Child. If Dependent Coverage is not already in effect for at least one other Dependent Child, then to continue the child's coverage beyond the first 60 days of coverage, You must notify Us of the child's adoption or Placement for Adoption and give Written permission to deduct Contributions from Your pay for Dependent Insurance for the adopted child. You must do this within 60 days of the date the child is adopted by You or Placed for Adoption with You.

The effective date of insurance for a newly adopted child will be determined without regard to whether the child is under a Medical Restriction.

**Placed for Adoption** or **Placement for Adoption** means the assumption and retention by You of a legal obligation for total or partial support of a child in anticipation of Your adoption of the child.

### **Other Dependents**

Dependent Insurance for a Dependent who is not under a Medical Restriction will take effect on the later of:

- the date You are enrolled for Dependent Insurance for such Dependent; or
- the date a person becomes Your Dependent.

If a Dependent is under a Medical Restriction on the date insurance for such Dependent would otherwise take effect, insurance for the Dependent will take effect on the date the Dependent is no longer under a Medical Restriction.

## ACCIDENTAL DEATH BENEFITS

Payment of the Accidental Death Benefits described in this section is subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

### BASIC ACCIDENTAL DEATH BENEFIT

We will pay the applicable Basic Accidental Death Benefit shown in the Schedule for a Covered Person's death if:

- the death results directly from an Accident; and
- the death occurs within 180 days following the Accident.

### Reduction of the Basic Accidental Death Benefit

The Basic Accidental Death Benefit will be reduced by the following if paid for Injuries sustained by the Covered Person in the same Accident that resulted in the Covered Person's death:

- the amount of any benefits paid under the Accidental Dismemberment/Functional Loss/Paralysis Benefits section of this Certificate; and
- the Modification Benefit under the Accident – Medical Treatment & Services Benefits section of this Certificate.

### ACCIDENTAL DEATH - COMMON CARRIER BENEFIT

We will pay the applicable Accidental Death – Common Carrier Benefit shown in the Schedule, instead of the Basic Accidental Death Benefit for a Covered Person's death if:

- the death results directly from an Accident sustained by the Covered Person while:
  - a fare paying passenger on a Common Carrier; or
  - a passenger on public transportation that is a Common Carrier, for which there is no fare; and
- the death occurs within 180 days following the Accident.

We will not pay both the Accidental Death - Common Carrier Benefit and the Basic Accidental Death Benefit for the same Covered Person.

**Common Carrier** means airplanes, trains, buses, trolleys, subways, and boats that:

- run on a regularly scheduled basis between predetermined points or cities; and
- are operated by a government regulated entity.

The term Common Carrier does not include taxis, limousines or privately chartered vehicles.

### Reduction of the Accidental Death – Common Carrier Benefit

The Accidental Death – Common Carrier Benefit will be reduced by the following if paid for Injuries sustained by the Covered Person in the same Accident that resulted in the Covered Person's death:

- the amount of any benefits paid under the Accidental Dismemberment/Functional Loss/Paralysis Benefits section of this Certificate; and
- the Modification Benefit under the Accident – Medical Treatment & Services Benefits section of this Certificate.



## ACCIDENTAL DISMEMBERMENT/ FUNCTIONAL LOSS/ PARALYSIS BENEFITS

Payment of the Accidental Dismemberment/Functional Loss/Paralysis Benefits described in this section are subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

### BASIC DISMEMBERMENT/FUNCTIONAL LOSS BENEFIT OR CATASTROPHIC DISMEMBERMENT/FUNCTIONAL LOSS BENEFIT

If a Covered Person sustains an Injury that is a Dismemberment or Functional Loss, We will pay the Basic Dismemberment/Functional Loss Benefit or the Catastrophic Dismemberment / Functional Loss Benefit shown in the Schedule that applies to the type of Dismemberment or Functional Loss the Covered Person sustained, subject to all of the following:

- The Dismemberment or Functional Loss must be documented by a Physician within 180 days after the Accident occurs.
- In order for the Catastrophic Dismemberment/ Functional Loss Benefit to be payable, the Injuries that qualify for such benefit must have been sustained by the Covered Person in a single Accident.
- If a Covered Person sustains an Injury that is a Dismemberment or Functional Loss that falls under more than one classification on the Schedule, We will only pay the benefit that applies to the classification that pays the highest benefit.

**Dismemberment** means any of the following:

- Loss of an arm: the arm is permanently severed at or above the elbow.
- Loss of a hand: the hand is permanently severed at or above the wrist joint.
- Loss of a finger: the finger is permanently severed at the joint proximate to the first interphalangeal joint where it is attached to the hand.
- Loss of a foot: the foot is permanently severed at or above the ankle joint.
- Loss of a leg: the leg is permanently severed at or above the knee.
- Loss of a toe: the toe is permanently severed at the joint proximate to the first interphalangeal joint where it is attached to the foot.

**Functional Loss** means any of the following:

- Loss of hearing: permanent deafness in at least one ear, such that it cannot be corrected to any functional degree by any procedure, aid or device. Loss of hearing must last for a continuous period of not less than 90 days as confirmed by a Physician.
- Loss of sight: permanent loss of sight in an eye. With correction, visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees. Loss of sight must last for a continuous period of not less than 90 days as confirmed by a Physician.
- Loss of ability to speak: total and permanent loss of audible communication (aphonia), if such loss cannot be corrected to any functional degree by any procedure, aid or device. Loss of ability to speak must last for a continuous period of not less than 90 days as confirmed by a Physician.

## **ACCIDENTAL DISMEMBERMENT/ FUNCTIONAL LOSS/ PARALYSIS BENEFITS (Continued)**

### **PARALYSIS BENEFIT**

If a Covered Person sustains an Injury that is Paralysis, We will pay the Paralysis Benefit shown in the Schedule that applies to the type of Paralysis that the Covered Person sustained, subject to all of the following:

- Paralysis must be documented by a Physician within 180 days after the Accident occurs.
- If a Covered Person sustains an Injury that is Paralysis that falls under more than one classification on the Schedule, We will only pay the benefit that applies to the classification that pays the highest benefit.
- We will pay the Paralysis Benefit no more than one time per Covered Person, per Accident.

**Paralysis** means the permanent total and irrecoverable loss of movement of 2 or more limbs:

- that has lasted for a continuous period of not less than 90 days as confirmed by a Physician; or
- as a result of transected spinal cord with supporting clinical and radiological evidence and no expectation of return to function.

The term Paralysis does not include a Dismemberment or Coma.

## ACCIDENTAL INJURY BENEFITS

Payment of the Accidental Injury Benefits described in this section are subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

### FRACTURE BENEFIT

If a Covered Person sustains an Injury that is a Fracture, We will pay the Fracture Benefit, shown in the Schedule that is applicable to the type of Fracture sustained by the Covered Person, subject to all of the following:

- The Injury must be diagnosed and treated as a Fracture by a Physician within 180 days after the Accident occurs.
- The Fracture must require, and be corrected by, open (surgical) or closed (non-surgical) reduction by a Physician. Closed reduction includes immobilization.
- We will pay no more than one Fracture Benefit per bone, per Accident.
- If more than one bone is Fractured in a single Accident, the amount We will pay for all Fractures combined will be no more than 2 times the highest Fracture Benefit that would otherwise be payable for any one of the bones involved.
- If an Injury is a Chip Fracture, We will pay the Chip Fracture Benefit instead of the Fracture Benefit. The Chip Fracture Benefit will be 25% of the Fracture Benefit shown in the Schedule for the bone involved.
- If the same Fracture is treated with both open reduction and closed reduction, We will pay no more than the Fracture Benefit payable for the open reduction.

**Fracture** means a break in a bone of a body part that is listed on the Schedule under Fracture Benefit, which can be detected by an x-ray or a similar diagnostic exam.

**Chip Fracture** means a Fracture in which a small fragment of the bone is broken off.

### DISLOCATION BENEFIT

If a Covered Person sustains an Injury that is a Dislocation, We will pay the Dislocation Benefit, shown in the Schedule, that is applicable to the type of Dislocation the Covered Person sustained, subject to all of the following:

- The Injury must be diagnosed and treated as a Dislocation by a Physician within 180 days after the Accident occurs.
- The Dislocation must require, and be corrected by, open (surgical) or closed (non-surgical) reduction by a Physician.
- If more than one joint is Dislocated in a single Accident, the amount We will pay for all Dislocations combined will be no more than 2 times the highest Dislocation Benefit that would otherwise be payable for any one of the joints involved.
- The Partial Dislocation Benefit will be 25% of the Dislocation Benefit shown in the Schedule for a Full Dislocation of the joint involved.
- If a Partial Dislocation Benefit was paid, or becomes payable, and the Covered Person subsequently sustains an Injury that is a Full Dislocation, We will reduce what We pay for the Full Dislocation by the amount that was paid, or is payable, for the Partial Dislocation.
- For each joint, We will pay no more than one Full Dislocation Benefit amount for all Injuries combined that are Dislocations of that same joint, regardless of whether the Injuries are sustained in the same Accident. Once the Covered Person has received an amount equal to one Full Dislocation Benefit for a joint, no further Dislocation Benefits will be paid for that same joint, even if the Covered Person subsequently sustains an Injury that is a Dislocation of that same joint in a new Accident.
- We will only pay benefits for those Dislocations specifically listed in the Schedule.

**Dislocation** means a separated joint of a body part that is listed on the Schedule under Dislocation Benefit. The term Dislocation does not include vertebral subluxation complex (misaligned vertebrae).

**Full Dislocation** means a Dislocation in which the joint is completely separated.

**Partial Dislocation** means a Dislocation in which the joint is not completely separated.

## **ACCIDENTAL INJURY BENEFITS (Continued)**

### **BURN BENEFIT**

If a Covered Person sustains an Injury that is a second or third degree burn, We will pay the Burn Benefit, shown in the Schedule, that is applicable to the size and severity of the burn, subject to all of the following:

- The burn must be treated by a Physician within 96 hours after the Accident occurs.
- If a burn meets more than one of the burn classifications shown in the Schedule, the amount We pay will be based on the classification of the burn that pays the highest benefit.
- We will pay the Burn Benefit no more than one time per Covered Person, per Accident.
- No benefit is payable for a first degree burn.

### **CONCUSSION BENEFIT**

If a Covered Person sustains an Injury that is a concussion, We will pay the Concussion Benefit shown in the Schedule, subject to all of the following:

- The Injury must be diagnosed as a concussion by a Physician within 96 hours after the Accident occurs.
- We will pay the Concussion Benefit no more than 1 time per Covered Person, per calendar year.

### **COMA BENEFIT**

If a Covered Person sustains an Injury that is a Coma or results in the Covered Person being placed in a medically induced Coma, We will pay the Coma Benefit shown in the Schedule, subject to all of the following:

- The Coma must begin within 180 days after the Accident occurs.
- We will pay the Coma Benefit no more than 1 time per Covered Person, per Accident.

### **LACERATION BENEFIT**

If a Covered Person sustains an Injury that is a Laceration and receives treatment from a Physician to repair it, We will pay the Laceration Benefit, shown in the Schedule, that is applicable to the length of the Laceration and the treatment received as follows:

- if the Laceration is repaired with stitches, We will pay the Laceration Benefit repaired with stitches; or
- if the Laceration is not repaired with stitches, We will pay the Laceration Benefit repaired without stitches.

Payment of the Laceration Benefit is subject to all of the following:

- The Laceration must be treated by a Physician within 96 hours after the Accident occurs.
- A Laceration repaired with sutures or staples will be deemed to be a Laceration repaired with stitches for purposes of this Laceration Benefit.
- If the Covered Person has more than one Laceration, the amount We pay will be based on the total length of all Lacerations received in any one Accident that are repaired with stitches. If some, but not all, of the Lacerations require repair with stitches, We will not pay any benefit for the Laceration or Lacerations that are repaired without stitches.
- We will pay the Laceration Benefit no more than:
  - one time per Covered Person, per Accident; and
  - no more than 3 times per Covered Person, per calendar year.

**Laceration** means a cut.

## **ACCIDENTAL INJURY BENEFITS (Continued)**

### **BROKEN TOOTH BENEFIT**

If a Covered Person sustains an Injury that is a broken tooth and the tooth is repaired by a dental crown or filling, or is extracted, We will pay the Broken Tooth Benefit, shown in the Schedule, that is applicable to the dental crown, filling and/or extraction, subject to all of the following:

- No benefit will be payable for an Injury to a tooth that is not a sound, natural tooth.
- No benefit will be payable for an Injury caused by biting or chewing.
- The dental services must begin within 180 days after the Accident occurs.
- Regardless of the number of teeth involved, We will pay the Broken Tooth Benefit for no more than 1 dental crown, no more than 1 dental filling, and no more than 1 dental extraction per Covered Person, per Accident.

### **EYE INJURY BENEFIT**

If a Covered Person sustains an Injury to an eye, We will pay the Eye Injury Benefit shown in the Schedule, subject to all of the following:

- The Injury to the eye must require Surgery or the removal of a foreign object by a Physician within 180 days after the Accident occurs.
- We will pay the Eye Injury Benefit no more than 1 time per Covered Person, per Accident.

## **ACCIDENT - MEDICAL TREATMENT & SERVICES BENEFITS**

**Payment of the Accident – Medical Treatment and Services Benefits described in this section are subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.**

### **AIR AMBULANCE BENEFIT**

We will pay the Air Ambulance Benefit shown in the Schedule if a licensed professional air ambulance service is required to transport a Covered Person by air to or from a Hospital or between medical facilities, where treatment for an Injury is received, subject to both of the following:

- The air ambulance transportation must be within 90 days after the Accident occurs.
- We will pay the Air Ambulance Benefit no more than 1 time per Covered Person, per Accident.

### **GROUND AMBULANCE BENEFIT**

We will pay the Ground Ambulance Benefit shown in the Schedule if a licensed professional ambulance service is required to transport a Covered Person by ground to or from a Hospital or between medical facilities, where treatment for an Injury is received, subject to both of the following:

- The ambulance transportation must be within 90 days after the Accident occurs.
- We will pay the Ground Ambulance Benefit no more than 1 time per Covered Person, per Accident.

### **EMERGENCY CARE BENEFIT OR NON-EMERGENCY INITIAL CARE BENEFIT**

If a Covered Person sustains an Injury and receives initial care from a Physician for the Injury in an Emergency Room, a Physician's office or an Urgent Care Facility, within 96 hours after the Accident occurs, We will pay the Emergency Care Benefit, shown in the Schedule that is applicable to the place where care is received.

If a Covered Person sustains an Injury and receives initial care from a Physician for the Injury in an Emergency Room, a Physician's office or an Urgent Care Facility, more than 96 hours but less than 180 days after the Accident occurs, We will pay the Non-Emergency Initial Care Benefit shown in the Schedule.

Payment of the Emergency Care Benefit and the Non-Emergency Initial Care Benefit is subject to both of the following:

- We will never pay both the Emergency Care Benefit and the Non-Emergency Care Benefit for the same Covered Person, for the same Accident.
- If We pay either the Emergency Care Benefit or the Non-Emergency Initial Care Benefit, We will pay the benefit no more than 1 time per Covered Person, per Accident.

## **ACCIDENT – MEDICAL TREATMENT & SERVICES BENEFITS (Continued)**

### **MEDICAL TESTING BENEFIT**

If a Covered Person sustains an Injury and receives any of the following medical tests to evaluate the Injury, We will pay the Medical Testing Benefit shown in the Schedule:

- x-rays;
- magnetic resonance imaging (MRI) or magnetic resonance (MR);
- ultrasound;
- nerve conduction velocity test (NCV);
- computed tomography scan (CT) or computed axial tomography (CAT); or
- electroencephalogram (EEG).

Payment of the Medical Testing Benefit is subject to all of the following:

- The test must be ordered by a Physician and be performed within 180 days after the Accident occurs.
- We will pay the Medical Testing Benefit no more than 2 times per Covered Person, per Accident.

### **PHYSICIAN FOLLOW-UP VISIT BENEFIT**

If a Covered Person sustains an Injury and receives follow-up care, for the Injury, that is recommended by a Physician or is a second opinion, We will pay the Physician Follow-Up Visit Benefit shown in the Schedule, subject to all of the following:

- Treatment must:
  - begin within 180 days after the Accident occurs and be provided within 365 days after the Accident occurs;
  - be specific to the Injury;
  - occur on an outpatient basis in a Physician's office, an Urgent Care Facility or a Hospital; and
  - not be for routine examinations, preventive testing, or any treatment for which a benefit is payable under the Therapy Services Benefit, Emergency Care Benefit or Non-Emergency Initial Care Benefit or Health Screening Benefit .
- We will pay the Physician Follow-Up Visit Benefit no more than:
  - 2 times per Covered Person, per Accident; and
  - 6 times per Covered Person, per calendar year.

### **TRANSPORTATION BENEFIT**

We will pay the Transportation Benefit shown in the Schedule when a Covered Person travels more than 50 miles one way for follow-up treatment of an Injury for which We pay a benefit under this Certificate, at a Hospital or other treatment facility, subject to all of the following:

- Mileage is measured from the Covered Person's Primary Residence to the facility where the follow-up treatment is provided.
- The follow-up treatment must be prescribed by a Physician and not available within 50 miles of the Covered Person's Primary Residence.
- You must submit Proof that the follow-up treatment was provided.
- We will not pay the Transportation Benefit if the Ground Ambulance Benefit or Air Ambulance Benefit is payable for the trip.
- We will pay the Transportation Benefit no more than:
  - 1 time per Covered Person, per Accident; and
  - 2 times per Covered Person, per calendar year.

## **ACCIDENT – MEDICAL TREATMENT & SERVICES BENEFITS (Continued)**

### **THERAPY SERVICES BENEFIT**

If a Covered Person sustains an Injury and receives Therapy Services, We will pay the Therapy Services Benefit shown in the Schedule that applies to the type of Therapy Service received, subject to all of the following:

- Therapy Services must:
  - begin within 180 days after the Accident occurs and be provided within 365 days after the Accident occurs;
  - be provided on an outpatient basis;
  - be prescribed by a Physician; and
  - be provided by a practitioner licensed to provide the type of Therapy Services provided and operating within the scope of such license.
- We will pay the Therapy Services Benefit for Therapy Services received no more than 10 times per Covered Person, per Accident.
- We will not pay a Therapy Services Benefit for Therapy Services received by the Covered Person on the same day for which the Inpatient Rehabilitation Benefit is payable.

**Therapy Services** means any of the following:

- cognitive behavioral therapy;
- occupational therapy;
- physical therapy;
- respiratory therapy;
- speech therapy;
- vocational therapy;
- acupuncture; or
- chiropractic therapy.

### **PAIN MANAGEMENT BENEFIT (FOR EPIDURAL ANESTHESIA)**

If a Covered Person sustains an Injury and receives epidural anesthesia to manage the pain from the Injury, We will pay the Pain Management Benefit shown in the Schedule, subject to all of the following:

- The epidural anesthesia must be administered within 180 days after the Accident occurs.
- Epidural anesthesia to manage the pain from the Injury must be prescribed by a Physician.
- We will pay the Pain Management Benefit no more than 1 time per Covered Person, per Accident.



## **ACCIDENT – MEDICAL TREATMENT & SERVICES BENEFITS (Continued)**

### **PROSTHETIC DEVICE BENEFIT**

If a Covered Person sustains an Injury that is a loss of a limb, hand, foot or sight in an eye and receives a Prosthetic Device as a result of the loss, We will pay the Prosthetic Device Benefit, shown in the Schedule, that is applicable to the number of Prosthetic Devices the Covered Person receives, subject to all of the following:

- The Prosthetic Device must be received within 365 days after the Accident occurs.
- No benefit will be payable for replacement of a Prosthetic Device.
- No benefit will be payable for more than one Prosthetic Device for the same body part.
- We will not pay the Prosthetic Device Benefit for a joint replacement such as an artificial hip or knee.
- We will pay the Prosthetic Device Benefit no more than 1 time per Covered Person, per Accident.

**Prosthetic Device** means an artificial device that replaces a missing body part. The term Prosthetic Device does not include hearing aids, dental aids (including false teeth), eyeglasses, or cosmetic prostheses such as wigs.

### **MEDICAL APPLIANCE BENEFIT**

If a Covered Person sustains an Injury for which a Physician prescribes the use of a Medical Appliance as an aid in personal locomotion or mobility, We will pay the Medical Appliance Benefit, shown in the Schedule, for the type of Medical Appliance that the Physician prescribes, subject to all of the following:

- The use of such Medical Appliance must begin within 180 days after the Accident occurs.
- The amount We will pay for all Medical Appliances combined, per Covered Person, per Accident, will be no more than the Medical Appliances Benefit Limit shown in the Schedule.
- We will not pay the Medical Appliance Benefit for the replacement of a Medical Appliance.

Medical Appliance means any of the following:

- brace for the neck, back or leg;
- cane;
- crutches;
- walker;
- walking boot that extends above the ankle;
- wheelchair or motorized scooter for medical purposes; and
- any other medical device used for mobility.

### **MODIFICATION BENEFIT**

If a Covered Person sustains an Injury for which We paid a Dismemberment, Functional Loss or Paralysis Benefit under this Certificate, We will pay the Modification Benefit shown in the Schedule for modifications made to the Covered Person's Primary Residence or vehicle, subject to all of the following:

- A Physician must certify that because of the Injury, the modification is necessary to help enable the Covered Person to live in his or her Primary Residence or travel in his or her primary vehicle.
- The modification must be made within 365 days after the Accident occurs.
- We will pay the Modification Benefit no more than 1 time per Covered Person, per Accident.

### **BLOOD / PLASMA / PLATELETS BENEFIT**

If a Covered Person sustains an Injury for which the Covered Person receives a transfusion of blood, plasma or platelets, We will pay the Blood/Plasma/Platelets Benefit shown in the Schedule, subject to all of the following:

- The blood, plasma or platelets must be prescribed by a Physician on an emergency basis or provided while the Covered Person is undergoing Surgery and must be administered within 180 days after the Accident.
- We will pay the Blood/Plasma/Platelets Benefit no more than 1 time per Covered Person, per Accident.

## **ACCIDENT – MEDICAL TREATMENT & SERVICES BENEFITS (Continued)**

### **SURGERY BENEFITS**

If a Covered Person undergoes Covered Surgery to treat an Injury, while Confined or in an Outpatient Surgery Facility, We will pay the applicable benefit shown in the Schedule under Surgery Benefits, for the type of Covered Surgery the Covered Person undergoes, subject to all of the following:

- The Covered Person must be treated by a Physician for the Injury within 180 days after the Accident occurs.
- The Covered Surgery must be performed by a Physician within 365 days after the Accident occurs.
- If the Covered Surgery is performed with repair, We will pay the Surgical Repair Benefit shown in the Schedule for the applicable procedure.
- If the Covered Surgery performed is Exploratory Surgery, We will pay the Exploratory Surgery Benefit shown in the Schedule.
- If as a result of the same Accident, the Covered Person has more than one Covered Surgery performed at the same time, We will only pay a benefit for one Covered Surgery, which will be the Covered Surgery with the highest benefit amount.
- If as a result of the same Accident, the Covered Person has a Covered Surgery and an Other Outpatient Surgery performed at the same time, We will only pay one benefit which will be the benefit that pays the higher amount.
- We will pay Surgery Benefits no more than 1 time per Covered Person, per Accident.

**Exploratory Surgery** means a Covered Surgery performed without surgical repair. For Surgery to treat torn cartilage in the knee, if cartilage is shaved or trimmed from the knee, the Surgery will be considered Exploratory Surgery and not a Surgery with repair.

### **OTHER OUTPATIENT SURGERY BENEFIT**

If a Covered Person sustains an Injury and undergoes Other Outpatient Surgery to treat the Injury in an Outpatient Surgery Facility, We will pay the Other Outpatient Surgery Benefit shown in the Schedule, subject to all of the following:

- The Covered Person must be treated by a Physician for the Injury within 180 days after the Accident occurs.
- The Surgery must be performed by a Physician in an Outpatient Surgery Facility within 365 days after the Accident occurs.
- If as a result of the same Accident, the Covered Person has a Covered Surgery and an Other Outpatient Surgery performed at the same time, We will only pay one benefit which will be the benefit that pays the higher amount.
- We will pay the Other Outpatient Surgery Benefit no more than 1 time per Covered Person, per Accident.

## HOSPITAL BENEFITS

Payment of the Hospital Benefits described in this section are subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

### ACCIDENT – HOSPITAL ADMISSION BENEFITS

#### Admission Benefit

If a Covered Person is admitted to a Hospital for treatment of an Injury, We will pay the Admission Benefit shown in the Schedule, for the day of admission, subject to all of the following:

- The admission must occur within 180 days after the Accident occurs.
- The Admission Benefit is not payable for Emergency Room treatment, outpatient treatment, or a stay of less than 20 hours in an observation area.
- We will only pay the Admission Benefit for a Covered Person for one Hospital admission at a time, even if the admission is caused by more than one Accident and/or Injury.
- We will pay the Admission Benefit no more than 1 time per Covered Person, per Accident.

#### ICU Supplemental Admission Benefit

If a Covered Person, upon initial admission to a Hospital for treatment of an Injury, is admitted to an ICU, We will pay the ICU Supplemental Admission Benefit shown in the Schedule, in addition to the Admission Benefit, if the admission meets the requirements for payment of the Admission Benefit, subject to both of the following additional requirements:

- The admission must occur within 180 days after the Accident occurs.
- If the Covered Person moves to an ICU after initial admission to a Hospital, We will not pay the ICU Supplemental Admission Benefit.

### ACCIDENT - HOSPITAL CONFINEMENT BENEFITS

#### Confinement Benefit

If a Covered Person is Confined in a Hospital for treatment of an Injury, We will pay the Confinement Benefit shown in the Schedule for each day, after the day of admission to the Hospital, the Covered Person is Confined in the Hospital, subject to all of the following:

- The initial Confinement must begin within 180 days after the Accident occurs.
- The Confinement Benefit is payable for up to 365 days per Covered Person, per Accident, and may be used over a two-year period following the date of the Accident.
- We will only pay the Confinement Benefit for a Covered Person for one Hospital Confinement at a time, even if the Confinement is caused by more than one Accident and/or Injury.
- We will only pay one Confinement Benefit per day.

#### ICU Supplemental Confinement Benefit

If a Covered Person is Confined in a Hospital for treatment of an Injury, We will pay the ICU Supplemental Confinement Benefit shown in the Schedule in addition to the Confinement Benefit, for each day the Covered Person is Confined in an Intensive Care Unit and meets the requirements for payment of the Confinement Benefit, subject to both of the following additional requirements:

- Confinement in the Intensive Care Unit must begin within 180 days after the Accident occurs.
- The ICU Supplemental Confinement Benefit is payable for up to 365 days per Covered Person, per Accident.

## **HOSPITAL BENEFITS (Continued)**

### **INPATIENT REHABILITATION BENEFIT**

If a Covered Person is transferred to a Rehabilitation Facility immediately after a period of Confinement for treatment of an Injury for which We paid an Admission Benefit or Confinement Benefit, We will pay the Inpatient Rehabilitation Benefit shown in the Schedule, subject to all of the following:

- We will pay the Inpatient Rehabilitation Benefit for each day of the Covered Person's continuous stay as a resident inpatient in a Rehabilitation Facility, up to a maximum stay of 15 days per Covered Person, per Accident but not to exceed 30 days per calendar year.
- The Covered Person's inpatient stay in the Rehabilitation Facility must start within 365 days after the Accident.
- After the Covered Person is discharged from the Rehabilitation Facility, We will not pay the Inpatient Rehabilitation Benefit for a subsequent admission to a Rehabilitation Facility for treatment of the same Injury for which We already paid the Inpatient Rehabilitation Benefit.
- We will not pay the Inpatient Rehabilitation Benefit for any day for which We paid a Confinement Benefit.

## OTHER BENEFITS

**Payment of the Other Benefits described in this section are subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.**

### HEALTH SCREENING BENEFIT

If a Covered Person takes one of the screening/prevention measures listed below while insured under this Certificate, upon submission of Proof, We will pay the Health Screening Benefit shown in the Schedule for the day that the measure is taken, subject to all of the following:

- We will only pay the Health Screening Benefit 1 time per Covered Person, per calendar year.
- We will not pay a Health Screening Benefit for a screening/prevention measure if benefits are paid or payable for that same screening/prevention measure under another section of this Certificate.

The screening/prevention measures for which a Health Screening Benefit may be paid are:

- routine health check-up exam
- biopsies for cancer
- blood chemistry panel
- blood test to determine total cholesterol
- blood test to determine triglycerides
- bone marrow testing
- breast MRI
- breast ultrasound
- breast sonogram
- cancer antigen 15-3 blood test for breast cancer (CA 15-3)
- cancer antigen 125 blood test for ovarian cancer (CA 125)
- carcinoembryonic antigen blood test for colon cancer (CEA)
- carotid doppler
- chest x-rays
- clinical testicular exam
- colonoscopy
- complete blood count (CBC)
- dental exam
- digital rectal exam (DRE)
- Doppler screening for cancer
- Doppler screening for peripheral vascular disease
- echocardiogram
- electrocardiogram (EKG)
- electroencephalogram (EEG)
- endoscopy
- eye exam
- fasting blood glucose test
- fasting plasma glucose test
- flexible sigmoidoscopy
- hearing test
- hemocult stool specimen
- hemoglobin A1C
- human papillomavirus (HPV) vaccination
- immunization
- lipid panel

## **OTHER BENEFITS (Continued)**

- mammogram
- oral cancer screening
- pap smears or thin prep pap test
- prostate-specific antigen (PSA) test
- serum cholesterol test to determine LDL and HDL levels
- serum protein electrophoresis
- skin cancer biopsy
- skin cancer screening
- skin exam
- stress test on bicycle or treadmill
- successful completion of smoking cessation program
- tests for sexually transmitted infections (STIs)
- thermography
- two hour post-load plasma glucose test
- ultrasounds for cancer detection
- ultrasound screening of the abdominal aorta for abdominal aortic aneurysms
- virtual colonoscopy
- coronavirus testing

### **LODGING BENEFIT**

If a Covered Person is Confined in a Hospital for treatment of an Injury, and a companion who accompanies the Covered Person while the Covered Person is so Confined stays in a Lodging for which a charge is made, We will pay the Lodging Benefit shown in the Schedule subject to all of the following:

- We will pay the Lodging Benefit for each day the companion stays in a Lodging while the Covered Person is Confined in a Hospital for treatment of an Injury.
- We will pay the Lodging Benefit for up to 15 days per Covered Person per calendar year.
- The Lodging Benefit is only payable for a day for which We are paying a Hospital Admission or Confinement Benefit for a Covered Person.
- You must submit Proof that the companion incurred an expense for staying at a Lodging for each day of the stay.

**Lodging** means an establishment licensed under the laws where it is located, such as a motel, hotel, or other facility that provides sleeping accommodations to the general public in exchange for a fee and is located at least 50 miles from the Covered Person's Primary Residence.

## EXCLUSIONS

We will not pay benefits for any loss for a Covered Person caused by the Covered Person's Sickness, or the diagnosis or treatment of such Sickness, except for the Covered Person's use of:

- any drug, medication or sedative that is taken or used as prescribed by a Physician; or
- an "over the counter" drug, medication or sedative taken as directed.

We will not pay benefits for any loss for a Covered Person caused or contributed to by:

- the Covered Person's voluntary use, by any means, of:
  - any drug, medication or sedative, unless it is:
    - taken or used as prescribed by a Physician; or
    - an "over the counter" drug, medication or sedative taken as directed;
  - alcohol in combination with any drug, medication, or sedative; or
  - poison, gas, or fumes;
- the Covered Person's suicide or attempted suicide (while sane or insane);
- the Covered Person's intentionally self-inflicted injury;
- war, whether declared or undeclared; or act of war;
- the Covered Person's active participation in an insurrection, rebellion, riot, or terrorist act;
- the Covered Person's engagement in any activity that constitutes a felony under the laws of the jurisdiction in which the activity occurred;
- the Covered Person's infection, other than infection occurring in an external wound resulting from an Injury;
- food poisoning;
- the Covered Person's operation, while intoxicated, of a motor vehicle involved in the incident. For purposes of this exclusion:
  - intoxicated means that the Insured's blood alcohol level met or exceeded .08%; and
  - motor vehicle means any vehicle that is powered by a motor, including, but not limited to: an automobile; a boat; a motorcycle; a truck; an all-terrain vehicle; or a snow mobile;
- dental or plastic Surgery for cosmetic purposes, except when such Surgery is performed to:
  - treat an Injury;
  - correct a disorder of normal bodily function or structure that was caused by an Injury for which coverage is not otherwise excluded under this Certificate; or
  - reconstruct a part of the body which was disfigured or removed as a result of an Injury for which coverage is not otherwise excluded under this Certificate;
- the Covered Person's mental illness, or the diagnosis or treatment of such mental illness, except for the Covered Person's use of:
  - any drug, medication or sedative that is taken or used as prescribed by a Physician; or
  - an "over the counter" drug, medication or sedative taken as directed;
- activities required by the Covered Person's service in the armed forces or any auxiliary unit of the armed forces of any country or international authority;
- the Covered Person's travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight;
- the Covered Person parachuting or otherwise exiting from a motorized or non-motorized aircraft while such aircraft is in flight, except for self-preservation;
- the Covered Person riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
- the Covered Person participating in any semi-professional or professional competitive athletic activity for which any type of compensation or remuneration is received; or
- the Covered Person bungee jumping, base jumping, hang gliding, para-kiting, sail-gliding, scuba diving deeper than 130 feet; spelunking; or mountaineering including rock climbing using ropes and any other climbing equipment. For the purposes of this exclusion the term mountaineering does not include backpacking, mountain biking, hiking or trail running.

## **EXCLUSIONS (Continued)**

In addition, We will not pay benefits for:

- a Covered Person while incarcerated in any type of penal or detention facility; or
- any of the following outside of the United States, Canada or Mexico:
  - any medical or healthcare treatment, services or transportation described in the Accident – Medical Treatment & Services Benefits section of this Certificate;
  - any inpatient admission or stay in any medical or health care facility.



## WHEN INSURANCE ENDS

**Please Note: If insurance ends under this section, in certain cases it may be continued as stated in the Continuation of Insurance section of this Certificate. Please see that section for details.**

Termination of a Covered Person's insurance in accordance with this section, will be without prejudice to an existing claim.

### DATE YOUR INSURANCE ENDS

Your insurance under this Certificate will end on the earliest of:

- the date the Group Policy ends;
- the date You die;
- the date insurance ends for Your class;
- the end of the period for which the last full premium has been paid for Your insurance;
- the end of the calendar month in which You notify Us that You wish to cancel Your insurance;
- the end of the calendar month in which You cease to be in an eligible class, subject to the Change in Class provision of the Eligibility Provisions: Insurance for You section; or
- the end of the calendar month in which Your employment ends.

### For residents of Massachusetts:

If You are a resident of Massachusetts and Your insurance under this Certificate is ending under the above provision because Your employment has ended, instead of insurance ending on the date Your employment ends, the following timelines apply:

- If Your employment ends for any reason other than a Plant Closing or a Partial Plant Closing, Your insurance will end 31 days after the date Your employment ends. However, if during such 31 day period You become entitled to benefits under another policy that are similar to the benefits provided under this Certificate, insurance under this Certificate will end on the date You become entitled to such other benefits.
- If Your employment ends due to a Plant Closing or a Partial Plant Closing Your insurance will end 90 days after the date Your employment ends. However, if during such 90 day period, You become entitled to benefits under another policy that are similar to the benefits provided under this Certificate insurance under this Certificate will end on the date You become entitled to such other benefits.

### DATE DEPENDENT INSURANCE ENDS

A Dependent's insurance under this Certificate will end on the earliest of:

- the date Your insurance under this Certificate ends;
- the date Dependent Insurance ends under the Group Policy for all employees or for Your class;
- the end of the calendar month in which the person ceases to be a Dependent;
- the end of the calendar month in which You cease to be in a class that is eligible for Dependent Insurance;
- the end of the calendar month in which the Dependent is no longer eligible as described in the Eligible Classes for Dependent Insurance provision; or
- the end of the period for which the last full premium has been paid for insurance for the Dependent.

### CHANGE IN CLASS

If there is more than one class eligible for insurance under the Group Policy, and each class has its own certificate, instead of receiving a new certificate when You move between classes, You will remain insured under this Certificate if:

- You move to a class that is eligible for Accident Insurance under the Group Policy; and
- the benefits available to Your new class are identical to the benefits available under this Certificate.

In all other cases when You move between classes, Your insurance under this Certificate will end on the date You are no longer a member of the class eligible for insurance under this Certificate.

## CONTINUATION OF INSURANCE

### AT YOUR OPTION: CONTINUATION WITH PREMIUM PAYMENT

If Your insurance ends under the Date Your Insurance Ends provision of this Certificate, in certain situations, it may be continued for You and Your Dependents, as described in this provision. This is referred to in this provision as "Continued Insurance". Evidence of insurability will not be required to obtain Continued Insurance. For purposes of this provision, insurance in effect under the Group Policy for which the Group Policyholder remits premium is referred to in this provision as "Group Billed Insurance".

Except as described below, Continued Insurance is subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

#### Requirements for Continued Insurance

Continued Insurance will be available to You if:

- Your Group Billed Insurance ends for any reason other than:
  - non-payment of premium or Contribution; or
  - the end of the Group Policy, provided that Continued Insurance will be available to You if You do not become eligible, within 30 days after the end of the Group Policy, for accident insurance under another policy of group insurance available through the Group Policyholder;
- We receive Your completed Written request for Continued Insurance on a form approved by Us within 31 calendar days after Your Group Billed Insurance ends; and
- You pay premiums required for Continued Insurance by the due date specified in the premium notice sent to You.

#### Changes in Continued Insurance

You may elect to decrease Your insurance after the date that Continued Insurance goes into effect for You if a lower benefit option is available. In addition, You may end insurance for any or all of Your Dependents. Please contact Us for information. You may not increase insurance once Continued Insurance goes into effect.

#### Contributions for Continued Insurance

The Contribution that You must pay for Continued Insurance is the amount of Your Contribution for Your Group Billed Insurance before it ended, plus any amount of premium that the Group Policyholder paid. The Contribution that You must pay for Continued Insurance will be determined on the same basis as premium rates charged for Group Billed Insurance. We have the right to change premium rates in accordance with the terms set forth in the Group Policy. All payments for Continued Insurance must be made directly to Us by the due date specified in the premium notice We send to You.

#### End of Continued Insurance

Continued Insurance will end on the earliest of the following dates:

- the date You die;
- if You do not pay a Contribution that is required for Continued Insurance, the end of the period for which the last full premium has been paid for Your insurance;
- with respect to Continued Insurance for a Dependent:
  - the date Continued Insurance for You ends for any reason;
  - the end of the calendar month in which the Dependent no longer meets the definition of a Dependent; or
  - the end of the calendar month in which the Dependent is no longer eligible as described in the Eligibility Provisions: Dependent Insurance section of this Certificate.

## **CONTINUATION OF INSURANCE (Continued)**

### **FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN**

Insurance for a Dependent Child may be continued past the age limit if that child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to Us within 31 days after the date the Dependent Child attains the age limit and at reasonable intervals after such date, but no more often than annually after the two year period following such Dependent Child's attainment of the limiting age.

Except as stated in the Date Dependent Insurance Ends provision of the When Insurance Ends section of this Certificate, insurance will continue while such Dependent Child:

- remains incapable of self-sustaining employment because of a mental or physical handicap; and
- continues to qualify as a Dependent Child, except for the age limit.

### **FOR FAMILY AND MEDICAL LEAVE**

Certain leaves of absence may qualify under the Family and Medical Leave Act of 1993 (FMLA) or similar state laws for continuation of insurance. Please contact the Group Policyholder for information regarding the FMLA or any similar state law.

## CLAIMS

### NOTICE OF CLAIM

You must give Us notice of a claim under this Certificate by Writing to Us or calling Us at the toll free number shown on the face page of this Certificate within 30 days of the date of the loss.

### CLAIM FORM

When We receive notice of a claim under this Certificate, We will provide You or the claimant (for a death claim) with a claim form. If We do not provide the claim form within 15 days from the date We received notice of claim, Our claim form requirements will be satisfied if We are provided with the required Proof in support of the claim.

### PROOF OF LOSS

Proof must be provided to Us not later than 90 days after the date of the loss. If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible, but in no event, other than in the absence of the legal capacity of the claimant, later than 12 months from the date of the loss.

### PAYMENT OF BENEFITS

When We receive the claim form and Proof, We will review the claim and, if We approve it, We will pay benefits subject to the terms and provisions of this Certificate and the Group Policy. Benefits will be paid within twenty-five (25) days after Our receipt of a clean claim submitted electronically, and will be paid within thirty-five (35) days after Our receipt of a clean claim submitted in paper format, subject to the terms and provisions of this Certificate and the Group Policy. For purposes of this provision, a "clean claim" means a claim for benefits under the Certificate that requires no further information, adjustment or alteration by You or by a Physician in order for Us to process and pay it. A clean claim does not include:

- claims which are submitted fraudulently or that are based upon material misrepresentations; and
- claims that require information essential to Us to administer pre-existing condition provisions.

If We do not deny payment of benefits under this Certificate by the end of the respective 25 day or 35 day period for clean claims, and such benefits remain due and payable to You, interest will accrue on the amount of such benefits at the rate of 1 ½ percent per month until such benefits are finally settled. If We do not pay such benefits to You when due and payable, You may bring action to recover such benefits and any interest which has accrued with respect to such benefits and any other damages which maybe allowed by law.

Unless You have assigned this insurance, all benefits to be paid under this Certificate will be paid to You, except as follows:

- If You are not alive to receive benefits that are payable to You, We will pay any benefits in accordance with the provision below titled Your Beneficiary.
- If You are living when benefits are to be paid to You, but You are not legally competent to claim or receive the benefits, We may pay up to \$1,000 to anyone related to You by blood or marriage who We believe is entitled to payment of the benefits. If We make such a payment in good faith, We will not be liable to anyone for the amount We pay. Any remaining benefits will be paid to Your legal representative.

If benefits have been assigned, We will pay benefits in accordance with the Assignment provision of the General Provisions section.

## CLAIMS (Continued)

### YOUR BENEFICIARY

A beneficiary may be named by You to receive any benefit that becomes payable to You under this Certificate that You are not alive to receive.

You may request to change Your beneficiary at any time. A beneficiary change request must be made to Us in Writing. Once the request is recorded, the change will take effect as of the date You sign the request, whether or not You are living when We receive the request. The change will be subject to any legal restrictions. It will also be subject to any payment We made or action We took before We recorded the change. If You designated two or more beneficiaries and their shares are not specified, they will share the benefit payable equally.

If there is no beneficiary designated or no surviving beneficiary at Your death, We will determine the beneficiary according to the following order:

1. Your Spouse, if alive;
2. Your child(ren), if there is no surviving Spouse;
3. Your parent(s), if there is no surviving child;
4. Your sibling(s), if there is no surviving parent; or
5. Your estate, if there is no surviving sibling.

Instead of making payment in the order above, We may pay Your estate. Any payment made in good faith will discharge Our liability to the extent of such payment. If a beneficiary or a Payee is a minor or incompetent to receive payment, We will pay that person's guardian.

### HOW WE WILL PAY ACCIDENTAL DEATH BENEFITS

A benefit due under the Accidental Death Benefits section of this Certificate will be paid in one sum to the Payee. Unless the Payee requests payment by check, when this Certificate states that We will pay benefits in "one sum", We may pay the full benefit amount:

- by check;
- by establishing an account that earns interest and provides the Payee with immediate access to the full benefit amount; or
- by any other method that provides the Payee with immediate access to the full benefit amount.

Other modes of payment may be available upon request.

**Payee** means a person to be paid a benefit under the Accidental Death Benefits section of this Certificate as determined in accordance with this Payment of Benefits provision.

## **CLAIMS (Continued)**

### **AUTHORIZATIONS**

We may require that You provide authorization for Us to obtain medical information and any other information pertinent to Your claim.

### **EXAMINATIONS**

During the pendency of a claim, at Our expense and as often as is reasonably necessary, We may require a Covered Person to have an independent examination by a Physician of Our choice.

During the pendency of a claim, at Our expense and as often as is reasonably necessary, We may have Our representatives conduct telephone or in-person interviews with You regarding Your claim.

### **TIME LIMIT ON LEGAL ACTIONS**

A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends three years after the date such Proof is required to be filed.

## **GENERAL PROVISIONS**

### **ENTIRE CONTRACT**

Your insurance is provided under a contract of group insurance with the Group Policyholder. The entire contract with the Group Policyholder is made up of the following:

- the Group Policy and its Exhibits, which include the Certificate(s);
- the Group Policyholder's application; and
- any amendments and/or endorsements to the Group Policy.

### **INCONTESTABILITY: STATEMENTS MADE BY YOU**

Any statement made by You will be considered a representation and not a warranty. We will not use such a statement to void insurance, reduce benefits or defend a claim unless the following requirements are met:

- the statement is in a form that is in Writing;
- You have Signed the form; and
- a copy of the form has been given to You or Your beneficiary.

We will not use Your statements which relate to insurability to contest this insurance after it has been in force for 2 years, unless the statement is fraudulent. In addition, We will not use such statements to contest a benefit increase after the benefit increase has been in force for 2 years, unless such statement is fraudulent.

### **MISSTATEMENTS**

If Your or Your Dependent's age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or Contributions.

### **ASSIGNMENT**

The benefits under the Group Policy are not assignable prior to a claim, except as required by law.

### **CONFORMITY WITH LAW**

If the terms and provision of this Certificate do not conform to any applicable law, this Certificate shall be interpreted to so conform.

### **STANDARD OF TIME**

All insurance becomes effective and terminates at 12:01 A.M. Eastern Standard Time, or at 12:01 A.M. Eastern Daylight Time if Daylight Savings Time is then being observed.

### **ACCESS TO DISCOUNTS FOR SERVICES**

You will receive access to discounts for certain services, where available.