

# Berkley Life and Health Insurance Company



Urbandale, Iowa  
Underwriting Office:  
2445 Kuser Road, Suite 201  
Hamilton Square, NJ 08690

## ADMINISTRATIVE CHANGE RIDER

This Rider is attached to and made a part of Policy Number KSA L031020067404 issued to Menifee County School District (the Policyholder).

Effective 07/01/2022, the Policy is renewed and **SCHEDULE OF BENEFITS** in the Policy is amended as follows:

The **POLICY PERIOD** is changed to 07/01/2022 to 07/01/2023.

The **POLICY NUMBER** is changed to KSA L031020067405.

The **PREMIUM** is changed to:

Total Amount Due: \$13,758.00

Premium Schedule: Annual paid 30 days From the Effective Date

This Rider does not change any other provisions of the Policy.

Signed for the Company:

President

Secretary

# Berkley Life and Health Insurance Company

Urbandale, Iowa  
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## Economic Sanctions Endorsement

This Endorsement attaches to and is made part of Policy Number KSA L031020067405 issued to Menifee County School District.

This Endorsement is subject to all the provisions, limitations, and exclusions of the Policy, except as they are specifically modified herein. In the event any provision of the Policy and this Endorsement conflict, the terms of this Endorsement shall govern. Please read this Endorsement carefully.

### U.S. ECONOMIC AND TRADE SANCTIONS CLAUSE

Whenever coverage provided by this Policy would be in violation of any U.S. economic or trade sanctions such as, but not limited to, those sanctions administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC"), such coverage shall be null and void. Similarly, any coverage relating to or referred to in any certificates or other evidences of insurance or any claim that would be in violation of U.S. economic or trade sanctions as described above shall also be null and void.

All other terms, conditions, limitations, and exclusions of the Policy remain unchanged.

**EFFECTIVE DATE OF ENDORSEMENT:** 07/01/2022

Signed for the Company:

President

Secretary

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The **POLICY NUMBER** is changed to KSA L031020067404.

The **PREMIUM** is changed to:

Total Amount Due: \$13,758.00

Premium Schedule: Annual paid 30 days From the Effective Date

This Rider does not change any other provisions of the Policy.

Signed for the Company:

A handwritten signature in black ink, appearing to be 'D. M. [unclear]', written over a horizontal line.

President

A handwritten signature in black ink, appearing to be 'A. J. [unclear]', written over a horizontal line.

Secretary

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All other terms, conditions, limitations, and exclusions of the Policy remain unchanged.

**EFFECTIVE DATE OF ENDORSEMENT:** 07/01/2021

Signed for the Company:

President

Secretary

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## ADMINISTRATIVE CHANGE RIDER

This Rider is attached to and made a part of Policy Number KSA L031020067403 issued Menifee County School District (the Policyholder).

Effective 07/01/2020, it is understood and agreed that Covered Activities is amended to include the following:

Covered Activities shall include while participating in Work Based Learning opportunities at local employers, earning credits toward graduation. Covered Activities also include online student learning activities that are sponsored, scheduled and directed by the Policyholder. Online student learning activities are the educational lessons directed and provided by the Policyholder to the Covered Person during normal school hours through remote online learning. Coverage includes direct group travel to and from such activities.

All other terms, conditions, limitations, and exclusions of the Policy remain unchanged.

This Rider does not change any other provisions of the Policy.

Signed for the Company:

A handwritten signature in black ink, appearing to be 'D. M. B. S.', written in a cursive style.

President

A handwritten signature in black ink, appearing to be 'A. J. G.', written in a cursive style.

Secretary

# Berkley Life and Health Insurance Company

Urbandale, Iowa  
Underwriting Office:  
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Hamilton Square, NJ 08690



## Blanket Accident Policy

**Policyholder:** Menifee County School District  
**Policy Number:** KSA L031020067402  
**Effective Date:** July 1, 2019  
**State of Issue:** Kentucky

This Policy is a legal contract between the Policyholder and Berkley Life and Health Insurance Company (herein referenced as "the Company"). The Company agrees to provide insurance to the Policyholder, in exchange for the payment of the required premium. Coverage is subject to the terms and conditions described in this Policy.

This Policy and the coverage provided by it become effective at 12:01 A.M. at the address of the Policyholder on the Policy Effective Date shown above. It continues in effect in accordance with the provisions set forth in this Policy.

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

Signed for the Company, as of the Effective Date above:

A handwritten signature in black ink, appearing to be 'A. J. [unclear]', written over a horizontal line.

President

A handwritten signature in black ink, appearing to be 'J. [unclear]', written over a horizontal line.

Secretary

**THIS IS A BLANKET ACCIDENT INSURANCE POLICY.  
THE POLICY DOES NOT PAY BENEFITS FOR LOSSES CAUSED BY SICKNESS.  
THIS IS A LIMITED POLICY.  
PLEASE READ THE POLICY CAREFULLY.**

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## SCHEDULE OF BENEFITS

**POLICYHOLDER:** Menifee County School District

**POLICY EFFECTIVE DATE:** July 1, 2019

**POLICY NUMBER:** KSA L031020067402

**POLICY PERIOD:** July 1, 2019 through July 1, 2020

### **CLASSES OF ELIGIBLE PERSONS:**

A person may be covered only under one Class of Eligible Persons even though He or She may be eligible under more than one class.

Class 1 All registered students, teachers and coaches of the Policyholder.

### **Premium**

Total Amount Due: \$14,660.00

Premium Schedule: Annual paid 30 days From the Effective Date

### **AGGREGATE LIMIT OF LIABILITY:**

Benefit Maximum	\$500,000
Applies During	Per Covered Accident
Applies To	Accidental Death & Dismemberment Benefits only

### **HAZARDS INSURED AGAINST:**

<u>Class</u>	<u>Description of Hazard</u>
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**Class 1:**

School Coverage  
Sports Coverage

#### **Covered Activity(ies):**

- The policy covers each eligible person during the policy period while he or she is: A) participating in school related activities; 1) sponsored by the Plan Sponsor; and 2) on the premises designated and supervised by the Policyholder; or B) traveling with a group in connection with the activities under the direct supervision of the Policyholder; or C) while participating as a member of a team in intramural, club or interscholastic competitive sports activities sponsored and supervised by the Policyholder.



## ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Principal Sum: \$10,000  
Time Period for Loss: 180 days

## ADDITIONAL ACCIDENT BENEFITS

Any benefits payable under these Additional Accident Benefits shown below are paid in addition to any Accidental Death and Dismemberment benefits payable, unless otherwise excluded or indicated under the terms, conditions, and exclusions of this Policy.

### Coma Benefit

1% of the Principal Sum for the first 11 months, subject to 100% of the Principal Sum amount

## DEFINITIONS

The male pronoun includes the female whenever used.

For the purposes of this Policy the capitalized terms used herein are defined as follows:

**ACCIDENT** means a sudden, unexpected event that results in Injury to the Covered Person.

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

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

**COVERED EXPENSES** means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies covered by this Policy. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained.

**COVERED LOSS or COVERED LOSSES** means an accidental death, dismemberment or other Injury covered under this Policy and indicated on the Schedule of Covered Losses.

**COVERED PERSON** means an eligible person who is within the covered class(es) listed in the Policy, who is a U.S citizen residing in the United States, or if not a U.S. citizen, resides permanently in the United States, and for whom the required premium is paid when due.

**DEDUCTIBLE** means the dollar amount of Covered Expenses that must be incurred by the Covered Person as an out-of-pocket expense for each Accident, before Accident Medical Expense Benefits and/or other Additional Benefits paid on an expense incurred basis are payable under this Policy.

**DOMESTIC PARTNER** means an opposite or same sex partner who, for at least 12 consecutive months, has resided with the Covered Person and shared financial assets/obligations with the Covered Person. Both the Covered Person and the Domestic Partner must: (1) intend to be life partners; (2) be at least the age of consent in the state in which they reside; and (3) be mentally competent to contract. Neither the Covered Person nor the Domestic Partner can be related by blood to a degree of closeness that would prohibit a legal marriage, be married to anyone else, or have any other Domestic Partner. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

**EXTENDED CARE FACILITY** means an institution operating pursuant to applicable laws, that is engaged in providing, for a fee, inpatient skilled nursing care and related services under the supervision of a Physician and registered nurses. It must have facilities for 10 or more inpatients and maintain medical records of all its patients.

**HOME HEALTH CARE** means nursing care, treatment and Daily Living Services provided in the Covered Person's home as part of an overall extended treatment plan. To qualify for Home Health Care Benefits:

- 1) the Home Health Care plan must be established and approved by the attending Physician, including certification that confinement in a Hospital or Extended Care Facility would be required if it were not for Home Health Care;
- 2) nursing care and treatment must be provided by a Hospital certified to provide Home Health Care services or by a certified Home Health Care agency and nursing service; and
- 3) Daily Living Services must be provided by the attending Physician or by the provider of the nursing care service.

"Daily Living Services" are cooking, feeding, bathing, dressing and personal hygiene services that are necessary to a person's care and health.

**HOSPITAL** means an institution that:

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

Hospital also includes ambulatory surgical centers approved by the Kentucky health facilities and health services certificate of need and licensure board. Charges for health care treatment or services rendered by an ambulatory surgical center shall be covered on the same basis as charges for the same health care treatment or services rendered by a Hospital.

We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following:

- 1) the Joint Commission of Accreditation of Hospitals; or
- 2) the American Osteopathic Association; or
- 3) the Commission on the Accreditation of Rehabilitative Facilities.

**HOSPITAL CONFINED/HOSPITAL STAY** means a stay/confinement of 24 or more consecutive hours as a registered resident bed-patient in a Hospital.

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

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

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

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

- 1) required to treat an Injury;
- 2) prescribed or ordered by a Physician or furnished by a Hospital;
- 3) performed in the least costly setting required by the condition;
- 4) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

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

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

**PHYSICIAN** means a legally licensed practitioner of the healing arts including, but not limited to, physicians, osteopaths, optometrists, certified surgical assistants, physician assistants, podiatrists, licensed nurses, chiropractors or dentists, practicing within the scope of his or her license to treat the condition causing loss. It does not include a member of the Covered Person's Immediate Family.

**TELEHEALTH** means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment and transfer of medical data.

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

**WE, OUR, US** means Berkley Life and Health Insurance Company underwriting this insurance.

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

## **ELIGIBILITY FOR INSURANCE**

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

- 1) the Covered Person is eligible, if the Covered Person has Dependents on that date; or
- 2) the date the person becomes a Dependent

If the Covered Person is in a Class of Eligible Persons and is also eligible as a Dependent, He or She may be Covered only once under this Policy. In no event will a Dependent be eligible if the Covered Person is not eligible.

## **EFFECTIVE DATE OF INSURANCE**

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

### **Covered Person's Effective Date**

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

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

## **TERMINATION DATE OF INSURANCE**

### **Policy Termination Date**

Termination takes effect at 12:01 A.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination.

This Policy terminates automatically on the earlier of:

- 1) The Policy Termination Date shown in this Policy; or
- 2) The premium due date if premiums are not paid when due subject to any grace period.

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

This Policy may be terminated by the Policyholder or the Company as of any premium due date or Policy Anniversary Date by giving written notice to the other at least 31 days prior to such date.

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

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

### **Covered Person's Termination Date**

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

- 1) The date this Policy terminates;
- 2) The date the Covered Person enters full-time active duty in the armed forces of any country or international authority;

- 3) The date the Covered Person ceases to be eligible as described in the Policy provided all required premiums are paid;  
or
- 4) The last day of the period for which premiums have been paid.

**EXTENSION OF BENEFITS:** In the event of a Covered Person's Total Disability at the date of termination of the Policy, benefits will be extended for such Covered Person for 90 days for Covered Medical Expenses incurred during the period of disability or incurred within a period of 90 days starting with a Covered Accident which occurred while coverage was in force.

## **PREMIUMS**

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

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

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

### **Changes in Premium Rate**

The Company may change the premium rates from time to time with at least 31 days advanced written or authorized electronic notice. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more than once in a 12 month period. However, the Company reserves the right to change rates at any time if any of the following events occur:

- 1) A change in the terms of the Policy.
- 2) An affiliated organization or eligible class is added or deleted to the Policy.
- 3) A change in any federal or state law or regulation affecting this Policy and Our benefit obligation.
- 4) A change in the factors bearing on the risk assumed.
- 5) A misrepresentation in the information relied on in establishing the rate for this Policy.
- 6) A change in the experience rating.

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

### **Grace Period**

After the payment of the first premium, this Policy will have a 31 day grace period. This means that if premium is not paid on or before the date it is due, it may be paid during the 31 day grace period. During this time, this Policy will stay in force provided the Policyholder pays all the premiums due by the last day of the grace period. This Policy will terminate on the last day of the period for which all premiums have been paid if the Policyholder fails to pay all premiums due by the last day of the grace period.

### **Reinstatement**

The Policy may be reinstated within 31 days of lapse if it is lapsed for nonpayment of premium, if the Policyholder submits written application to the Company, the Company accepts the application and the Policyholder makes payment of all overdue premiums.

## **HAZARDS INSURED AGAINST**

We will pay benefits described in this Policy when a Covered Person suffers a Covered Loss or Injury as a result of a Covered Accident during one of the Covered Activities listed in the Schedule of Benefits.

### **SCHOOL COVERAGE**

We will pay the benefits described in the Policy for an Accident which occurs to a Covered Person:

- 1) While in or on School grounds or premises during a period of regular attendance during the days and months when School is in session;
- 2) While traveling directly and without delay to or from the Covered Person's Residence and School for regular classroom sessions, for such travel time as may be necessary, within one hour before School begins and one hour after dismissal from School, or longer if a school bus requires;
- 3) While participating in or attending School Sponsored Activities and directly and continuously supervised by a School official or employee, subject to the limitations of the Policy. This includes supervised travel by School furnished transportation, directly and uninterrupted to and from School Sponsored Activities; and
- 4) While attending religious classes, either on or away from the School premises, including travel directly to or from the Covered Person's Residence or School and the place where such classes are held.

"Residence" means the property on which the Covered Person dwells.

"School" means the Policyholder's school facility where the Covered Person attends classes.

"School Sponsored Activities" means functions solely organized scheduled and directly supervised by qualified School authorities while on or off the School premises.

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

### **SPORTS COVERAGE**

We will pay the benefits described in the Policy for an Accident which occurs while a Covered Person is:

- (1) taking part in:
  - (a) a regularly scheduled athletic game or competition; or
  - (b) a practice session for an athletic team or club; or
- (2) traveling to or from such a game, competition or practice session provided he is;
  - (a) traveling with the athletic team or club; and
  - (b) under the direct and immediate supervision of:
    - (i) the athletic team or club; or
    - (ii) an adult authorized by the athletic team or club; or
- (3) traveling directly, without interruption:
  - (a) between his home and a scheduled game, competition or practice session;
  - (b) in a vehicle which is:
    - (i) operated by a properly licensed driver, and
    - (ii) travel time does not exceed an hour each way.

Travel time includes the time:

- (1) to or from home, a scheduled game, competition or practice session;
- (2) before required attendance time;
- (3) after the Covered Person is dismissed; and

(4) after the Covered Person completes extra duties assigned by the Policyholder.

Conditions which result over a period of time (such as blisters, tennis elbow, heat exhaustion, hernia, etc.), and which are a normal, foreseeable result of the sport, are not covered. These items are considered a sickness and are not covered.

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

**DESCRIPTION OF BENEFITS**

All benefits payable are shown in the Schedule of Benefits.

**ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT**

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

**Schedule of Covered Losses**

<b><u>Loss of:</u></b>	<b><u>Benefit:</u></b>
	(Percentage of Principal Sum/Amount of Insurance)
Life.....	100%
Brain Death.....	100%
Quadriplegia.....	100%
Two or More Members.....	100%
One Member.....	50%
Hemiplegia.....	75%
Paraplegia.....	75%
Uniplegia.....	25%
Thumb and Index Finger of the Same Hand.....	25%
Four fingers of the Same Hand.....	25%

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

“Brain Death” means irreversible unconsciousness with total loss of brain function; and complete absence of electrical activity of the brain, although the heart is still beating.



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

“Paraplegia” means total Paralysis of both lower limbs or both upper limbs.

“Quadriplegia” means total Paralysis of both upper and lower limbs.

“Uniplegia” means total Paralysis of one lower limb or one upper limb.

### **Aggregate Limit of Liability**

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

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

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## **ADDITIONAL ACCIDENT BENEFITS**

### **Coma Benefit**

If a Covered Person suffers an Injury caused by an Accident which results in such person being in a Coma within 90 days of the Accident and if the Coma continues for at least 30 consecutive days, the Company will pay monthly benefits equal to 1% of the Covered Person’s Principal Sum, the sum of which shall not exceed 100% of the Covered Person’s Principal Sum.

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

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

If the Covered Person suffers loss of life for which Accidental Death Benefits are payable under this Policy as a result of the same Accident which caused the Coma, or if He or She remains in a Coma at the end of 11 continuous months, an additional benefit will be paid equal to the Covered Person’s Amount of Insurance less any Coma Benefits paid or other benefits payable under this Policy for any other losses incurred as a result of the same Accident.

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

The Covered Person’s designated beneficiary is responsible for providing the Company proof of continuing Coma. The Company reserves the right, at the end of the first 30 consecutive days of Coma and as often as it may reasonably require thereafter, to determine, on the basis of all the facts and circumstances, that the Covered Person is in a Coma, including requiring an independent medical examination provided at the expense of the Company.



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

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### EXCLUSIONS

This Policy does not cover any loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of any of the following even if the immediate cause of the loss is an accidental bodily Injury, unless otherwise covered under this policy by Additional Benefits:

1. Suicide, self-destruction, attempted self-destruction or intentional self-inflicted Injury while sane or insane.
2. War or any act of war, declared or undeclared.
3. Service or Active Duty in the armed forces, National Guard, military, naval or air service or organized reserve corps of any country or international organization.
4. Sickness, disease or any bacterial infection, except one that results from an accidental cut or wound or pyogenic infections that result from accidental ingestion of contaminated substances.
5. We shall not be liable for any loss sustained or contracted in consequence of the Covered Person’s being intoxicated or under the influence of any narcotic or any hallucinogenic unless administered on the advice of a Physician.
6. Violation or in violation or attempt to violate any duly-enacted law or regulation, or commission or attempt to commit an assault or felony, or that occurs while engaged in an illegal occupation.
7. Conditions that are not caused by a Covered Accident.
8. Covered Expenses for which the Covered Person would not be responsible in the absence of this Policy.
9. Injuries paid under Workers’ Compensation, Employer’s liability laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.
10. Services or treatment rendered by a Physician, Nurse or any other person who is employed or retained by the Policyholder; or an Immediate Family member of the Covered Person.
11. Treatment of a detached retina unless caused by an Injury suffered from a Covered Accident.
12. Pregnancy, childbirth, miscarriage, abortion or any complications of any of these conditions.
13. Mental or nervous disorders, except as specifically provided in this policy.
14. Damage to or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in this Policy.
15. Expense incurred for treatment of temporomandibular or craniomandibular joint dysfunction and associated myofacial pain, except as specifically provided in this Policy.
16. Loss resulting from participation in any activity not specifically covered by this Policy.
17. Any treatment, service or supply not specifically covered by this Policy.
18. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
  - i. While riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
  - ii. While being used for any test or experimental purpose; or
  - iii. While piloting, operating, learning to operate or serving as a member of the crew thereof; or
  - iv. While traveling in any such aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Covered Person or any member of his household.

Except as a fare paying passenger on a regularly scheduled commercial airline.

## CLAIMS PROVISIONS

**NOTICE OF CLAIM:** Written notice of death or Injury must be given to the Company within 30 days after a Covered Loss begins or as soon as reasonably possible. Notice can be given to the Company at Health Special Risk, Inc., 4100 Medical Parkway, Carrollton, TX 75007-1517, 866-523-3269. Notice should include the Covered Person's name and address as well as this Policy Number. If written notice is not received within 30 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

- 1) it can be shown that it was not possible within reason to submit notice within the 30 day period; and
- 2) it is further shown that notice was given as soon as possible.

**CLAIM FORMS:** When the Company receives a notice of claim, the Company will send forms for filing proof of loss. If claim forms are not sent within 15 days after receipt of such notice, Proof of Loss requirements stated below will be deemed to have been met if, within the Proof of Loss time period specified below, written proof of the nature and extent of the loss is submitted.

**PROOF OF LOSS:** Written proof of loss must be given to the Company within 180 days after the date of loss. If the proof of loss is not submitted within 180 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

- 1) it can be shown that it was not possible within reason to submit notice within the 180 day period; and
- 2) it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

**TIME OF PAYMENT OF CLAIMS:** Benefits for loss covered by this Policy, other than benefits that require periodic payment, will be paid as soon as the Company receives proper written proof of such loss. Benefits for loss covered by this Policy that require periodic payment shall be paid monthly provided that the Company receives proper written proof of such loss.

**PAYMENT OF CLAIMS:** All benefits will be paid in United States currency. Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of this Policy entitled 'General Policy Provisions'. To receive proceeds, a beneficiary must be living on the earlier of the following dates: the date the Company receives proof of the loss of life; or the 10<sup>th</sup> day after the death.

All other benefits will be paid to the Covered Person suffering the loss. If the Covered Person dies before all payments due have been made, the amount still payable will be paid to his/her beneficiary as described in the Designation and Change of Beneficiary provision of this Policy entitled 'General Policy Provisions'.

**EXPOSURE AND DISAPPEARANCE:** A Covered Person will be presumed to have died due to covered Injuries, if while insurance is in effect He suffers Covered Loss due to exposure to the elements.

A Covered Person will be presumed to have died, if, while insurance is in effect and after the forced landing, stranding, sinking or wrecking of a covered vehicle:

- 1) He disappears; and

- 2) His body is not found within a year of the Accident; and
- 3) a valid death certificate or other legal proof of death is issued by a court of appropriate jurisdiction.

**PHYSICAL EXAMINATIONS AND AUTOPSY:** We have the right to have a Physician of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy.

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

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

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

Only the amount recovered for charges incurred will be subject to Refund. One-third of the Net Recovery will be deemed to be for such charges. However, in no case will the amount of Refund exceed the amount of benefits paid for the Injury under this Policy.

The right of Refund also applies when the Covered Person recovers under an uninsured or underinsured motorist plan.

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

“Net Recovery” means the Covered Person's Recovery less attorney's fees and court costs incurred in making the Recovery.

“Refund” means repayment to Us for benefits paid.

## **GENERAL POLICY PROVISIONS**

**ENTIRE CONTRACT/CHANGES:** This Policy and all endorsements, amendments and attached papers is the entire contract between the Policyholder and the Company.

Any statement made by the policyholder or by a Covered Person shall in the absence of fraud be deemed a representation and not a warranty, and no such statements shall be used in defense to a claim under the Policy and this Certificate, unless contained in a written application.

Changes to this Policy may be made at any time by an endorsement or amendment and must be agreed upon, in writing, between the Policyholder and the Company. The Company may also, upon 31 days written notice to the Policyholder, change or modify the provisions of this Policy to comply with any applicable requirements of the Internal Revenue Service and/or any state or other federal law or regulation. No agent may change this Policy or waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** In the absence of fraud, all statements made by the Policyholder or by a Covered Person shall be deemed representations and not warranties. No such statement shall be used to contest this Policy or reduce benefits unless contained in a signed, written application, a copy of which has been provided to the

person who made the statement, or to their beneficiary or representative. No such statement will be used to contest this Policy after this Policy has been in force for two years.

Such person, his beneficiary or assignee shall have the right to make a written request to Us for a copy of such application, and We shall within 15 days after the receipt of such request at Our principal office or any branch office, deliver or mail to the person making such request a copy of such application. If such copy is not so delivered or mailed, We shall be precluded from introducing such application as evidence in any action based upon or involving any statements contained therein.

**CLERICAL ERROR:** Clerical error in keeping any records pertaining to the coverage, whether by the Policyholder or by the Company, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to the Company and is rectified promptly upon discovery.

**CONFORMITY WITH STATE STATUTES:** Any provision of this Policy in conflict on its effective date with the laws of the State of Issue indicated on the front page of this Policy is amended to conform to the minimum requirements of such laws.

**DESIGNATION OR CHANGE OF BENEFICIARY:** Each Covered Person may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order of preference:

- 1) Beneficiaries designated in writing by the Covered Person for this Policy on file with the Policyholder, if any, otherwise;
- 2) Beneficiaries as designated in writing for any group life insurance plan or its renewals in force for the Policyholder, if any, otherwise;
- 3) In equal shares to the members of the first surviving class of those that follow, if any:
  - a) a Covered Person's lawful spouse, if not legally separated or divorced, or Domestic Partner;
  - b) a Covered Person's natural Child, adopted Child, foster Child, stepchild, or other Child for whom the Covered Person has or had legal guardianship (proof will be required); or
  - c) a Covered Person's parents, whether natural, step or adoptive; otherwise.
- 4) The estate of the Covered Person.

A Covered Person may change his/her beneficiary designation from time to time without the consent of the designated beneficiary by giving notice, in writing, to the Policyholder. When a request for designation or change is received by the Policyholder, it will take effect on the date of its execution, whether or not the Covered Person is living on the date it is received by the Policyholder. Any interest created by the request will be subject to any payment made or action taken before its receipt.

**ASSIGNMENT:** No assignment of interest in loss of life benefits shall be binding on the Company until the original or duplicate thereof is received by the Company. The Company assumes no responsibility for the validity of such assignment.

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

**LEGAL ACTION:** All Policy terms will be interpreted under the laws of the state in which this Policy was issued. No legal action may be brought to recover on this Policy within 60 days after written Proof of Loss has been furnished. No legal action may be brought after three (3) years from the time written Proof of Loss is required to be furnished.

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

**REPLACEMENT COVERAGE FROM PRIOR CARRIER:** If the group policy replaces the group policy of another insurer the prior insurer shall remain liable only to the extent of its accrued liabilities, extension of benefits, and for persons who are under continued group health insurance coverage at the time the group policy terminates.

Our liability will be as follows:

- (a) Each Covered Person who is eligible for coverage shall be covered by our plan on the effective date of coverage.
- (b) When applying any deductibles or waiting periods in our plan, we shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior group policy. In the case of deductible provisions, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible provisions of the prior insurer's group policy during the ninety (90) days preceding the effective date of the group policy, but only to the extent these expenses are recognized under the terms of the new group policy and are subject to similar deductible provisions.
- (c) If a determination of the prior insurer's benefit is required by Us, at our request the prior insurer shall furnish a statement of the benefits available or pertinent information sufficient to permit verification of the benefit determination or the determination itself by Us. Benefits of the prior insurer's group policy shall be determined in accordance with all of the definitions, conditions, and covered expense provisions of the prior insurer's group policy rather than those of this group policy. The benefit determination shall be made as if coverage had not been replaced by Us.

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

**WORKERS' COMPENSATION:** This Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.

# Berkley Life and Health Insurance Company

Urbandale, Iowa  
Underwriting Office:  
2445 Kuser Road, Suite 201  
Hamilton Square, NJ 08690



## Accident Medical And Dental Expense Benefit Endorsement

This Endorsement attaches to and is made part of Policy Number KSA L031020067402 issued to Menifee County School District.

This Endorsement is subject to all the provisions, limitations, and exclusions of the Policy, except as they are specifically modified herein. In the event any provision of the Policy and this Endorsement conflict, the terms of this Endorsement shall govern. Please read this Endorsement carefully.

**THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS BENEFIT DOES NOT SATISFY THE “MINIMUM ESSENTIAL COVERAGE” REQUIREMENTS UNDER THE AFFORDABLE CARE ACT. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.**

### SCHEDULE OF BENEFITS

This Benefit Endorsement applies to the following Class(es) of Covered Persons while such persons are participating in the conditions of coverage specified in the Hazard/Covered Activity described below:

<u>CLASS</u>	<u>HAZARD/COVERED ACTIVITY</u>
Referenced in policy schedule	
<b>Accident Medical and Dental Expense Benefit</b>	
Maximum Amount for all Covered Accidental Medical and Dental Expenses Incurred	\$25,000.00
Co-Insurance Factor (for all Covered Accidental Medical and Dental Expenses)	100%
Deductible	\$0
Terms of Payment	Full Excess
Loss Period (first Covered Expenses must be incurred within):	180 days from the date of the Covered Accident
Benefit Period:	104 weeks from the date of the Covered Accident

**Deferred Treatment Expense Benefits:**

**Deferred Dental Expenses**

Maximum Benefit

\$25,000

Benefit Period

to age 28

Accident Medical Expense benefits may be available on an allocated or unallocated basis as shown, that is to say there may be specific limits or coinsurance rates on certain Covered Expenses (allocated) or all Covered Expenses may be subject to the same maximum limit and coinsurance factor (unallocated).

<b><i>Inpatient Hospital Services:</i></b>	
Hospital Miscellaneous Expense (including general nursing care and pre-admission testing performed within 3 working days prior to admission)	\$5,000
<b><i>Outpatient Hospital Services:</i></b>	
Hospital Miscellaneous Expense	\$1,000
Day Surgery Miscellaneous (including supplies, drugs and services in connection with scheduled outpatient day surgery)	\$5,000
<b><i>Other Services:</i></b>	
Combined X-Ray and Diagnostic Imaging Services	\$500
Orthopedic Braces and Appliances	\$500
Outpatient Physical Therapy	\$40 for the first visit, and \$40 for each subsequent visit for a maximum of 10 visits, limited to one visit per day
Prescription Drugs	\$100
Dental Services	\$500 per tooth

Any Deductibles, Coinsurance, Benefit Periods, and Benefit Maximums apply on a per Covered Person, per Covered Accident basis.

**DESCRIPTION OF BENEFITS**

**ACCIDENT MEDICAL AND DENTAL EXPENSE BENEFIT**

We will pay Accident Medical and Dental Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident. These benefits are subject to the Deductibles, Coinsurance Factors, Benefit Periods, Benefit Maximums and other terms or limits shown below and in the Schedule of Benefits.

Accident Medical Expense Benefits are only payable:

- 1) for Usual and Customary Charges incurred after the Deductible has been met;
- 2) for those Medically Necessary Covered Expenses incurred by or on behalf of the Covered Person;
- 3) for Covered Expenses incurred within the Loss Period stated in the Schedule of Benefits.

No benefits will be paid for any expenses incurred that are in excess of Usual and Customary Charges.



Covered Medical Expenses, from a Covered Accident, include:

- 1) Hospital room and board expenses: the daily room rate when a Covered Person is Hospital Confined and general nursing care is provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
- 2) Ancillary Hospital expenses: services and supplies including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) when Hospital Confined.
- 3) Daily Intensive Care Unit/Cardiac Care Unit Expenses: the daily room rate when a Covered Person is Hospital confined in a bed in the Intensive Care Unit/Cardiac Care Unit and nursing services other than private duty nursing services.
- 4) Medical Emergency Care (room and supplies) expenses incurred within 72 hours of a Covered Accident and including the attending Physician's charges, x-rays, laboratory procedures, use of the emergency room and supplies.
- 5) Outpatient surgery expenses, including Ambulatory Surgical Center.
- 6) Outpatient surgical room and supply expenses for use of the surgical facility.
- 7) Outpatient diagnostic x-rays, laboratory procedures and test expenses.
- 8) Physician non-surgical treatment/examination expenses (excluding medicines) including the Physician's initial visit, each necessary follow-up visit and consultation visits when referred by the attending Physician.
- 9) Second surgical opinion expenses.
- 10) Physician surgical expenses. If an Injury requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Covered Expenses for the additional surgeries.
- 11) Assistant Surgeon expenses when Medically Necessary.
- 12) Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
- 13) Outpatient laboratory test expenses.
- 14) Physiotherapy (physical medicine) expenses on an inpatient or outpatient basis limited to one visit per day; expenses include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, chiropractic, adjustments, manipulation, massage or any form of physical therapy.
- 15) Post surgical physical medicine expenses and office visits connected with such treatment when prescribed by a Physician.
- 16) X-ray expenses (including reading charges) not including dental x-rays.
- 17) Diagnostic imaging expenses including magnetic resonance imaging (MRI) and CAT scans.
- 18) Dental expenses including dental x-rays for the repair or treatment of each injured tooth that is whole sound and a natural tooth at the time of the Covered Accident.
- 19) Dental expenses related to the installation of crowns, caps, bridges and dentures; oral surgery and endodontics and repair or replacement of caps and crowns that existed prior to the Covered Accident.
- 20) Outpatient registered nurse services if ordered by a Physician.
- 21) Ambulance expenses for transportation from the Accident site to the Hospital.
- 22) Rehabilitative braces or appliances prescribed by a Physician. It must be durable medical equipment that is primarily and customarily used to serve a medical purpose and can withstand repeated use and generally is not useful to a person in the absence of Injury. No benefits will be paid for rental charges in excess of the purchase price.
- 23) Prescription drug expenses prescribed by a Physician and administered on an outpatient basis.
- 24) Medical equipment rental expenses for a wheelchair or other medical equipment that has therapeutic value for the Covered Person. We will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs.
- 25) Medical services and supplies for blood and blood transfusions; oxygen and its administration.
- 26) Eyeglasses, contact lenses and hearing aids when damage occurs in a Covered Accident that requires medical treatment.



- 27) Artificial limbs, eyes and larynx for initial acquisition and fitting. We will not pay for repair or replacement of artificial limbs, eyes or larynx.
- 28) Heart and circulatory conditions: expenses for treatment of heat exhaustion, heart attack, stroke, burst aneurysm if the condition occurs during a Covered Accident.
- 29) Mental or nervous disorders/psychotherapy expenses for treatment of a disorder that results directly or independently of all other causes from a Covered Accident, while Hospital confined or on an outpatient basis. Benefits are limited to one treatment per day. Mental and nervous disorders means neurosis, psychoneurosis, psychopathic, psychosis, or mental or emotional disease or disorder of any kind.
- 30) Rehabilitation care facility expenses for physical and occupational rehabilitation. Treatment must be provided in a duly licensed Rehabilitation Facility and be under the direction of a Physician. "Rehabilitation Facility" means a Hospital or special unit of a Hospital designated as a Rehabilitation Facility or a free standing facility which provides physical therapy, occupational therapy or speech therapy pursuant to the law of the jurisdiction in which treatment is received.
- 31) Extended Care Facility expenses for confinement if it begins within 10 straight days after a Covered Person is Hospital Confined as a result of a Covered Accident. We will pay for treatment if a Physician visits the Covered Person at least once every 30 days and certifies the confinement is Medically Necessary.
- 32) Expanded medical benefit for sports conditions for treatment of bursitis, sprains, hernia, strains, muscle tears, tendonitis and repetitive motion injuries if these conditions are aggravated by participation in a Covered Activity but only if the Covered Person's Physician has released him or her to participate in the Covered Activity during which the re-aggravation occurred.
- 33) Expenses due to an aggravation or re-injury of a prior Injury resulting from a Covered Accident.
- 34) Transportation expense for newborn Children for transporting the newborn to and from the nearest available facility appropriately staffed and equipped to treat Injuries resulting from a Covered Accident, when the transportation is certified by the attending Physician as Medically Necessary.

#### **DEFERRED TREATMENT EXPENSE BENEFITS**

The Company will pay the Benefit Amounts shown in the Schedule of Benefits, subject to all applicable conditions and exclusions, for the Covered Person's Covered Medical Expenses for Deferred Treatment Expenses, subject to the applicable maximum shown in the Schedule of Benefits, for treatment of a Covered Loss. Expenses charged to the Deferred Treatment Expense Benefit(s) are subject to the Accident Medical and Dental Expense Maximum.

**Deferred Treatment Expenses** are **Covered Medical Expenses** that:

1. are incurred after the end of the Benefit Period applicable to the Covered Loss requiring treatment but before the end of any applicable Deferred Treatment Benefit Period;
2. would have been Covered Medical Expenses had the services been incurred during the applicable Benefit Period;
3. are not in excess of the Maximum for Accident Medical and Dental Expense Benefits or the applicable Deferred Treatment Maximum; and
4. are submitted as a claim within 90 days of the end of the applicable Benefit Period, with a Physician's statement that treatment cannot be completed by the end of that Benefit Period, and with an estimate of cost and duration.

**Deferred Dental Expenses** are **Covered Medical Expenses incurred** for treatment, including X-rays, to repair injury to a tooth (1) with no fillings or cavities or only fillings or cavities that do not undermine the tooth cusps; and (2) for which pulpal tissues are healthy and intact; and (3) for which periodontal tissue shows little or no signs of active or chronic inflammation; or to the supporting structures of the teeth of the Covered Person. If there is more than one way to treat a dental problem, the Company will pay based on the least expensive procedure if that procedure meets commonly accepted standards of the American Dental Association.

## Terms of Payment for Accident Medical and Dental Expense Benefit

### Full Excess:

If a Covered Person incurs Covered Expenses, We will pay the applicable benefit, subject to any applicable Deductible, Coinsurance Factor, and Benefit Period shown on the Schedule of Benefits that are in excess of expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan. The first expense must be incurred within the Loss Period stated on the Schedule of Benefits. The Total Benefit Maximum payable and sub-limits under the Policy are shown on the Schedule of Benefits.

For the purposes of this provision, "Health Care Plan" means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:

- (1) group or blanket insurance, whether on an insured or self-funded basis;
- (2) hospital or medical service organizations on a group basis;
- (3) Health Maintenance Organizations on a group basis;
- (4) group labor management plans;
- (5) employee benefit organization plan;
- (6) professional association plans on a group basis; or
- (7) any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended.

All other terms, conditions, limitations, and exclusions of the Policy remain unchanged.

**EFFECTIVE DATE OF ENDORSEMENT:** 07/01/2019

Signed for the Company:



President



Secretary

# Berkley Life and Health Insurance Company

Urbandale, Iowa  
Underwriting Office:  
2445 Kuser Road, Suite 201  
Hamilton Square, NJ 08690



## BLANKET INSURANCE AMENDATORY ENDORSEMENT

This Endorsement attaches to and is made part of Policy Number KSA L031020067402 issued to Menifee County School District.

This Endorsement is subject to all the provisions, limitations, and exclusions of the Policy, except as they are specifically modified herein. In the event any provision of the Policy and this Endorsement conflict, the terms of this Endorsement shall govern. Please read this Endorsement carefully.

### ACCIDENT MEDICAL AND DENTAL EXPENSE BENEFIT

#### DESCRIPTION OF BENEFITS

The ambulance expenses included in the list of Covered Medical Expenses under the Accident Medical and Dental Expense Benefit is hereby deleted and replaced with the following:

Ambulance expenses for ground and air transportation to transport the Covered Person from the Accident site to the nearest medical facility. If such facility is not equipped to provide the level of care needed, and a Physician specifies in writing that an additional transport is Medically Necessary then ambulance expenses means from the first medical facility to another medical facility.

All other terms, conditions, limitations and exclusions of the Policy remain unchanged.

**EFFECTIVE DATE OF ENDORSEMENT:** 07/01/2019

Signed for the Company:

A handwritten signature in black ink, appearing to be 'L. M. ...'.

A handwritten signature in black ink, appearing to be 'J. ...'.

# Berkley Life and Health Insurance Company

Urbandale, Iowa  
Underwriting Office:  
2445 Kuser Road, Suite 201  
Hamilton Square, NJ 08690



## Economic Sanctions Endorsement

This Endorsement attaches to and is made part of Policy Number KSA L031020067402 issued to Menifee County School District.

This Endorsement is subject to all the provisions, limitations, and exclusions of the Policy, except as they are specifically modified herein. In the event any provision of the Policy and this Endorsement conflict, the terms of this Endorsement shall govern. Please read this Endorsement carefully.

### U.S. ECONOMIC AND TRADE SANCTIONS CLAUSE

Whenever coverage provided by this Policy would be in violation of any U.S. economic or trade sanctions such as, but not limited to, those sanctions administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC"), such coverage shall be null and void. Similarly, any coverage relating to or referred to in any certificates or other evidences of insurance or any claim that would be in violation of U.S. economic or trade sanctions as described above shall also be null and void.

All other terms, conditions, limitations, and exclusions of the Policy remain unchanged.

**EFFECTIVE DATE OF ENDORSEMENT:** 07/01/2019

Signed for the Company:

A handwritten signature in black ink, appearing to be 'L. J. ...', written over a horizontal line.

President

A handwritten signature in black ink, appearing to be 'J. ...', written over a horizontal line.

Secretary

## **BERKLEY LIFE AND HEALTH INSURANCE COMPANY**

### **PRIVACY NOTICE**

Berkley Life and Health Insurance Company (the "Company"), a member company of the W. R. Berkley Corporation ("Berkley") group of companies and each other member of the Berkley group of companies ("Affiliates") understands our customers' concern about privacy of their information collected by the Company. Our Company is dedicated to protecting the confidentiality and security of nonpublic personal information we collect about our customers in accordance with applicable laws and regulations. This notice refers to the Company by using the terms "us," "we," or "our." The law requires that we send you a notice describing our privacy policy and how we treat the nonpublic personal information about our customers that we receive in connection with our business (Information").

#### **Why We Collect and How We Use Information.**

We collect and use Information for business purposes with respect to our insurance products and services and other business relations involving our customers. We gather this Information to evaluate your request for insurance, to evaluate your insurance claims, to administer, maintain or review your insurance policy, and to process your insurance transactions. We also accumulate certain information about you as may be required or permitted by law.

Your insurance agent or broker also collects this Information and may use it to help with your overall insurance program or to market additional products and services to you. We may also use Information to offer you other products or services that we or our Affiliates provide.

#### **How We Collect Information.**

Most Information collected by us is provided by you or your insurance agent or broker to us. We obtain Information from (i) applications or other forms submitted by you, your insurance agent or broker or your authorized representatives to us and our Affiliates, and (ii) your transactions with us or our Affiliates. We may also obtain Information from other sources such as (i) consumer reporting agencies, (ii) other institutions or information services providers, (iii) employers, (iv) other insurers, or (v) your family members.

#### **Information We Disclose.**

We disclose any Information which we believe is necessary to conduct our business as permitted by applicable law or where required by applicable law. This disclosure may include (i) Information we receive from you on applications or other forms provided to us and our Affiliates, such as names, addresses, social security numbers, assets, employer information, salaries, etc. (ii) Information about your transactions with us and our Affiliates, such as policy coverages, premiums, payment history, etc., and (iii) Information we receive from a consumer reporting agency, such as credit worthiness and credit history.

#### **To Whom We Disclose Information.**

We may, as permitted or required by applicable law, disclose your Information to nonaffiliated third parties, such as (i) your insurance agent or broker, (ii) independent claims adjusters, (iii) insurance support organizations, (iv) processing companies, (v) actuarial organizations, (vi) law firms, (vii) other insurance companies involved in an insurance transaction with you, (viii) law enforcement, regulatory, or governmental agencies, (ix) courts or parties therein pursuant to a subpoena or court order, (x) businesses with whom we have a marketing agreement, or (xi) our Affiliates.

We may share Information with our Affiliates so that they may offer you products and services from the Berkley group of companies or to analyze our book of business and to consolidate necessary information. We do not disclose Information to other companies or organizations not affiliated with us for the purpose of using Information to sell their products or services to you. For example, we do not sell your name to unaffiliated mail order or direct marketing companies.

**How We Protect Information.**

We require our employees to protect the confidentiality of Information as required by applicable law. Access to Information by our employees is limited to administering, offering, servicing, processing or maintaining of our products and services. We also maintain physical, electronic and procedural safeguards designed to protect Information. When we share or provide Information to other persons or organizations, we contractually obligate them, if required by law, to treat Information as confidential and conform to our privacy policy and applicable laws and regulations.

**Correction and Access to Information.**

Upon our receipt of your written request to us at Berkley Life and Health Insurance Company, 475 Steamboat Road, Greenwich, Connecticut 06836-2519 we will, generally, make available Information for your review. If you believe the Information we have about you is incorrect or inaccurate, you may request that we make any necessary corrections, additions or deletions. If we agree with your belief, we will correct our records if required by applicable law. If we do not agree, you may submit to us a short statement of dispute, which we will include in any future disclosure by us of such Information if required by applicable law.

**Requirements for Privacy Notice.**

This privacy notice is being provided due to recently enacted federal and state laws and regulations establishing new privacy standards and requires us to provide this privacy policy. For additional information regarding our privacy policy, please write to us at 475 Steamboat Road, Greenwich, Connecticut 06836-2519.

Revised: February 7, 2006