

**DIocese OF COLUMBUS, OHIO – Policy # MCB 5465785
STUDENT AND ATHLETIC ACCIDENT PROGRAM – 2013-2014**

ELIGIBILITY

All enrolled students of the Policyholder. Any student who attends day care, pre-kindergarten, kindergarten, elementary or secondary school is eligible. Eligibility shall also extend to students participating in the latch key program run by the Diocese.

COVERAGE UNDER STUDENT ACCIDENT PLAN

While participating in any Policyholder sponsored and supervised non-athletic events; while participating in any Policyholder sponsored and supervised play or practice sessions for interscholastic athletic competitions or official tournaments including football; traveling directly and uninterrupted to and from such School Sponsored and Supervised Activity with other members as a group. Such travel must be supervised by an authorized representative of the School; traveling directly and uninterrupted to or from the Insured's home and the meeting place for the purpose of participating in a School Sponsored and Supervised Activity.

KEY DEFINITIONS

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

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

Covered Activity(ies) means those activities set out in the COVERED ACTIVITIES section of the Schedule.

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

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

Insured means any person who is eligible for coverage under this **Policy** as provided in the ELIGIBILITY AND CLASSIFICATION OF INSUREDS section of the Schedule, and who completes the enrollment material, if required.

Non-Contributory means the **Insured** is not required to contribute toward the premium. Whether the benefits are **Contributory** or **Non-Contributory** is stated in the Schedule.

Physician means a person who is:

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

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

Policy means this Blanket Accident Insurance Policy.

Policyholder means the entity named as such in the Schedule.

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

BASIS OF BENEFITS - Benefits will be paid at 80% of the Reasonable and Customary charge.

\$1,000,000 STUDENT ACCIDENT MEDICAL EXPENSE BENEFITS

Benefits will cover the Reasonable and Customary expenses for the medical services listed below which occur within 5 years of a per-son being injured, providing services commence within 90 days of the date of the accident subject to a Maximum Benefit of \$1,000,000.

1. **Hospital** room and board expenses: the daily room rate when an **Insured** is **Hospital Confined** and general nursing care is provided and charged for by the **Hospital**. In computing the expenses payable under this benefit, the date of admission will be counted but not the date of discharge.
2. Ancillary **Hospital** expenses: services and supplies including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) when **Hospital Confined**.
3. Medical emergency care (room and supplies) expenses incurred within twenty-four (24) hours of an **Accident** and including the attending **Physician's** charges, X-rays, laboratory procedures, use of the emergency room and supplies.
4. Outpatient surgical room and supply expenses for use of the surgical facility.
5. Outpatient diagnostic X-rays, laboratory procedures and tests.
6. **Physician** non-surgical treatment/examination expenses (excluding medicines) including the **Physician's** initial visit, each necessary follow-up visit and consultation visits when referred by the attending physician.
7. **Physician's** surgical expenses: If a **Covered Injury** requires multiple surgical procedures during the same operative session through the same or different incision, **We** will pay only one benefit, the largest of the procedures performed.
8. Assistant physician expenses when **Medically Necessary**.
9. The services of a registered nurse when **Medically Necessary** (the nurse cannot be a member of the **Insured's** immediate family).
10. Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
11. Outpatient laboratory test expenses.
12. Physiotherapy expenses on an inpatient or outpatient basis limited to one (1) visit per day to a maximum of twelve (12) visits. Expenses include treatment and office visits connected with such treatment when prescribed by a **Physician**, including diathermy, ultrasonic, whirlpool, or heat treatments, adjustments, manipulation, massage or any form of physical therapy.
13. X-ray expenses (including reading charges) but not for dental X-rays unless **Medically Necessary** to evaluate a **Covered Injury**.
14. Radiological procedures.
15. Diagnostic imaging expenses including Magnetic Resonance Imaging (MRI) and Computed Axial Tomography (CAT) Scan.
16. Ambulance expenses for transportation from the emergency site to the **Hospital**.
17. Rehabilitative braces or appliances prescribed by a **Physician**. It must be durable medical equipment that:
 - a. is primarily and customarily used to serve a medical purpose;
 - b. can withstand repeated use; and
 - c. generally is not useful to a person in the absence of injury.No benefits will be paid for rental charges in excess of the purchase price.
18. Prescription drug expenses, for **Covered Injuries**, prescribed by a **Physician** and administered on an outpatient basis.
19. Medical equipment rental expenses for a wheelchair or other medical equipment that has therapeutic value for an **Insured**. **We** will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs, eyeglasses and hearing aids.
20. Expenses for blood and blood transfusions; oxygen and its administration.

EXCLUSION AND LIMITATIONS

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

1. suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury.
2. war or any act of war, whether declared or undeclared.
3. involvement in any type of active military service.
4. illness or disease, regardless of how contracted.
5. participation in the commission or attempted commission of any felony;
6. being intoxicated.
 - a) An **Insured** will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.
 - b) An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the **Insured's** intoxication.
7. being under the influence of any prescription drug, controlled substance, or hallucinogen, unless such prescription drug, controlled substance, or hallucinogen was prescribed by a **Physician** and taken in accordance with the prescribed dosage.
8. travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight.
9. participation in any team sport or any other athletic activity unless mentioned in the **Covered Activities**.
10. any condition for which the **Insured** receives to benefits under any Workers' Compensation Act, No Fault Auto
 - a) Coverage or similar law.
11. the **Insured** riding in or driving any type of motor vehicle as part of a speed contest or scheduled race, including testing such vehicle on a track, speedway or proving ground.

In addition to the General Exclusions stated in the **Policy**, **We** will not cover expenses under this additional benefit for:

1. Cosmetic, plastic or restorative surgery unless **Medically Necessary** for the treatment of the **Covered Injury**.
2. Any medical expenses related to pregnancy unless **Medically Necessary** for the treatment of the **Covered Injury**.
3. **Covered Injury** for which the **Insured** receives benefits under Workers Compensation Benefits, Employer Liability Law, or any statutory mandated coverage.
4. Personal comfort or convenience items, such as but not limited to **Hospital** telephone charges, television rental, or guest meals.
5. Treatment by any immediate family member or member of the **Insured's** household.
6. Expenses incurred for dental care, treatment, repair or replacement of sound natural teeth unless **Medically Necessary** for the treatment of the **Covered Injury**.
7. Expenses incurred for eye examinations, eye glasses, contact lenses or hearing aids or the fitting, repair or replacement of these items unless **Medically Necessary** for the treatment of the **Covered Injury**.
8. Routine physical examinations and related medical services, or elective treatment or surgery, or experimental or investigative treatments or procedures.
9. Expenses incurred for psychological or psychiatric counseling of any kind or any expense for treatment of mental or nervous diseases or disorders.
10. Expenses which the **Insured** is not legally obligated to pay.
11. Expenses for **Custodial Services** or services provided by a private duty nurse unless such expenses are incurred as a result of a **Covered Injury**.
12. Expenses related to the repair or replacement of existing artificial limbs, eyes, or other prosthetic appliances, or rental of existing medical equipment unless for the purpose of modifying the item because the **Covered Injury** has caused further impairment of the underlying bodily condition.
13. Treatment involving conditions caused by repetitive motion injuries or cumulative trauma and not a result of a **Covered Injury**.
14. Treatment for osteochondritis due to overuse and occurring during periods of rapid growth, including but not limited to Osgood-Schlatter Disease.

CLAIMS PROCEDURES

In the event of an injury: 1. Notify the school/parish immediately; 2. Secure a claim form from the school/parish; 3. Complete the claim form, sign the claim form in all necessary places and remit with itemized bills to Administrative Concepts Inc, 994 Old Eagle School Road Suite 1005, Wayne, PA 19087-1802

UNDERWRITING INSURANCE COMPANY

This program is underwritten by Zurich American Insurance Company, Schaumburg, IL

PROGRAM ADMINISTRATOR

This program is administered by Bollinger Inc., 101 JFK Parkway, Short Hills, NJ 07078.

LOCAL BROKER - Willis of Ohio, 775 Yard St, Suite 200, Columbus Ohio 43212.