



Philadelphia, PA 19106

This is a Description of Coverage for:
National Intercollegiate Rodeo Association
Policy Number ADD NO0191334

Underwritten By: ACE American Insurance Company (referred to as "We," "Our," "Ours")

Eligibility: All members of the National Intercollegiate Rodeo Association for Injury sustained while they are: 1) participating in sanctioned association activities; or 2) traveling directly to or from these sanctioned activities.

Period of Coverage: You will be insured on the later of: 1) the Policy Effective Date; or 2) the date that You become eligible. Your coverage will end on the earlier of the date: 1) the policy terminates; 2) You are no longer eligible; or 3) the period ends for which the premium is paid.

Definitions: Accident: means a sudden, unexpected and unintended event. Covered Accident: means an Accident that occurs while Your coverage is in force and results in a loss or Injury covered by the Policy for which benefits are payable. Covered Activity: means any activity that the Policyholder requires You to attend, or that is under its supervision and control. Covered Expenses: means expenses actually incurred by You or on Your behalf for treatment, services and supplies covered by the 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. Doctor: means a licensed health care provider acting within the scope of his or her license and rendering care or treatment to You that is appropriate for the conditions and locality. It will not include You or a member of Your Immediate Family or household. Hospital: means an institution that: 1) operates as a Hospital pursuant to law for the care, treatment, and providing of 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 Doctors available at all times; 4) provides organized facilities for diagnosis, treatment and surgery, either (i) on its premises, or (ii) 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. Immediate Family: means Your parent, grandparent, spouse, child, brother, sister or in-laws. Injury: means accidental bodily harm sustained by You that results directly and independently from all other causes from a Covered Accident. The Injury must be caused solely through external, violent and accidental means. All injuries sustained by one person in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury. Medically Necessary: means a treatment, service, or supply that is: 1) required to treat an Injury or Sickness; 2) prescribed or ordered by a Doctor or furnished by a Hospital; 3) performed in the least costly setting required by Your condition; and 4) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered. Usual and Customary Charge: 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. You/Your: means a person insured under the policy.

Accidental Death and Dismemberment Benefits: If Your Injury results in any of the following losses within 365 days after the date of the Covered Accident, We will pay the amount shown below for that loss. If multiple losses occur, only one Benefit Amount, the largest, will be paid for all losses due to the same Covered Accident.

Table with 2 columns: Description of Loss and Indemnity. Rows include Life (\$10,000), Both Hands or Both Feet; Sight of Both Eyes (\$10,000), Quadriplegia (total paralysis of both upper and lower limbs) (\$10,000), One Hand and One Foot; Either Hand or Foot and Sight of One Eye (\$10,000), Either Hand or Foot or Sight of One Eye (\$5,000), Paraplegia (paralysis of both lower limbs) (\$5,000), Hemiplegia (\$5,000), and Thumb and Index Finger of the Same Hand (\$2,500).

The term "loss" means, with regard to hands and feet, actual severance through or above wrist or ankle joint, and with regard to eyes, entire irrecoverable loss of sight. "Paralysis" means loss of use, without severance, of a limb.

Accidental Medical Expense Benefits: We will pay Accident Medical Expense Benefits up to 70% of Covered Expenses that result directly, and from no other cause, from a Covered Accident. These benefits are subject to the Deductibles, Coinsurance Rates, Benefit Periods, Benefit Maximums and other terms or limits shown below. 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 that You receive; and 3) for charges incurred within 104 weeks after the date of the Covered Accident. The initial expense must be incurred within 180 days of the Accident that caused the Injury. No benefits will be paid for any expenses incurred that, in Our judgement, are in excess of Usual and Customary Charges. We pay Covered Expenses: 1) after You satisfy any Deductible; and 2) only when they are in excess of amounts paid by any other health care plan. We pay benefits without regard to any Coordination of Benefits provisions in any other health care plan. Covered Medical Expenses: 1) Treatment by a Doctor; 2) Care given by a Graduate Nurse; 3) Confinement in a Hospital; 4) Ambulance service to and from the Hospital; and 5) Services and supplies ordered by a Doctor; and 6) Treatment for an injury to sound, natural teeth.

**Deductible:** \$1,000 (The deductible will be \$500 if claims are submitted and benefits paid by another insurance company.)

**Total Maximum for all Covered Expenses under the Accident Medical Benefit:** \$25,000 per Covered Accident.

**Maximum Benefit Period:** 104 Weeks from the date of the Covered Accident causing the Injury

**Accident Disability Benefits:** We will pay the Disability Benefit of \$1,000 per month for 12 months if **You** suffer Paralysis within 30 days, and as a direct result of, and from no other cause but, a Covered Accident. Disability Benefits will begin after: 1) **You** are disabled for at least 30 days; and 2) **You** provide satisfactory proof of **Your** Paralysis. Benefit Payments will end on the first of the following dates: 1) the date **You** die; or 2) **You** no longer suffer from Paralysis; or 3) the date **You** fail to submit satisfactory proof of continuing Paralysis.

“Paralysis” means, due to an Injury from a Covered Accident, **You**: 1) suffer the loss of use, without severance, of a limb; and 2) this loss is determined by a Doctor to be complete and not reversible; and 3) **You** are Quadriplegic, Paraplegic or Hemiplegic as a direct result of the Accident. Quadriplegic means **You** suffer total paralysis of both upper and lower limbs; Paraplegic means **You** suffer total paralysis of both lower limbs; and Hemiplegic means **You** suffer total paralysis of upper and lower limbs on one side of the body.

**Coma Benefit:** We will pay \$1,000 per month if **You** become Comatose within 31 days of a Covered Accident and remain in a Coma for at least 31 days. We reserve the right, at the end of the first 31 days of Coma, to require proof that **You** remain Comatose. This proof may include, but is not limited to, requiring an independent medical examination at Our expense.

We will pay this benefit monthly. Periodic payments will end on the first of the following dates: 1) the end of the month in which **You** die; 2) the end of the 10<sup>th</sup> month for which this benefit is payable; or 3) the end of the month in which **You** recover from the Coma. **You** will be deemed “Comatose” or in a “Coma” if **You** are in a profound stupor or state of complete and total unconsciousness, as the result of a Covered Accident.

**Hospital Confinement Benefit:** We will pay \$50 per day up to \$1,500 if **You** are Hospital Confined as the direct result, and from no other causes, of Injuries sustained in a Covered Accident. The Hospital stay must begin within 30 days of a Covered Accident and last for at least 3 days in a row. Hospital Confinement Benefits will end on the first of the following: 1) the date the Hospital stay ends; 2) the date **You** die; 3) the date **Your** insurance ends; or 4) 30 days. Separate Hospital confinements due to Injuries from the same Covered Accident will be treated as one confinement unless separated by 6 months.

**Exclusions and Limitations:** We will not pay benefits for any loss or Injury that is caused by, or results from:

1. intentionally self-inflicted Injury.
2. suicide or attempted suicide.
3. war or any act of war, whether declared or not, or caused by taking part in a riot or civil disobedience.
4. service in the military, naval or air service of any country.
5. 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.
6. piloting or serving as a crewmember or riding in any aircraft except as a fare-paying passenger on a regularly scheduled or charter airline.
7. commission of, or attempt to commit, a felony or other illegal activity.
8. alcoholism, drug addiction or the use of any drug or narcotic except as prescribed by a Doctor.

In addition to the exclusions above, We will not pay Accident Medical Expense Benefits for any loss, treatment or services resulting from or contributed to by:

1. Treatment by persons employed or retained by a Policyholder, or by any Immediate Family or member of **Your** household.
2. Dental treatment, except as the result of an Injury to sound, natural teeth.
3. Injury covered by Workers’ Compensation, Employer’s Liability Laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.
4. Covered medical expenses for which mandatory automobile no-fault benefits are due.
5. Eye examinations or eyeglasses for the correction of vision, or the fitting of glasses.
6. Participation in any activity or hazard not specifically covered by the Policy.

**Claim Administration:** Health Special Risk, Inc., HSR Plaza II, 4100 Medical Parkway, Carrollton, Texas 75007, 1-877-534-7669.

**You** must notify Health Special Risk, Inc. within 90 days of an Accident or Loss. If notice cannot be given within that time, it must be given as soon as reasonably possible. This notice should identify **You** and the Policy Number.

*This Description of Coverage is a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the Policy issued to the National Intercollegiate Rodeo Association. The policy is subject to the laws of the state in which it was issued. Coverage may not be available in all states or certain terms or conditions may be different if required by state law. Please keep this information as a reference.*