

**SCHEDULE**

**SPONSORING ORGANIZATON GROUP NO.:** SR2014MO-P-110591

**SPONSORING ORGANIZATON INFORMATION:**

Food For Thought Denver  
3559 W. 44th Ave  
Denver, CO 80211

**Effective Date:** September 29, 2017

**Expiration Date:** September 29, 2018

**ELIGIBILITY:**

All registered volunteers performing tasks as assigned by the Policyholder/Sponsoring Organization listed on the Activity Report on file with Us.

**SCOPE OF COVERAGE:**

<u>Class</u>	<u>Insured Risk</u>	<u>Benefits</u>
ALL	Activity Coverage (IRACT068-MO)	AD&D (ADSLPERC001) AME (AME002-MO)

**BENEFITS:**

**Accidental Death & Specific Loss (ADSLPERC001)**

Loss of Life Principal Sum Amount	\$10,000.00
Single Specific Loss Principal Sum Amount	\$5,000.00
Double Specific Loss Principal Sum Amount	\$10,000.00
Loss Period	Loss within 180 Days of Injury

**Medical Expense for Accident (AME002-MO) - Full Excess (TBF004)**

Maximum Benefit Amount	\$25,000.00 per Injury
Deductible Corridor	\$100.00 per Injury
Loss Period	Initial treatment received within 30 days of Injury
Benefit Period	Benefits payable for 52 weeks from accident date

Dental Expense	
Maximum Benefit	100% of the Allowable Expense per tooth; not to exceed 100% of the Allowable Expense per Injury

Orthopedic Appliances	
Maximum Benefit	not to exceed 100% of the Allowable Expense per Injury

Outpatient Physical Therapy Expense	
Maximum Benefit	not to exceed 100% of the Allowable Expense per Injury

**PREMIUM:** \$0.50 per participant (Volunteering 1-2 Days), \$1.50 per participant (Volunteering 3-5 Days), \$3.00 per participant (Volunteering 6+ Days)

This plan has a non-refundable minimum premium of \$200.00 per policy year, which is fully earned on the date the coverage goes into effect.

10/5/17 HT  
VG

# MUTUAL OF OMAHA INSURANCE COMPANY

Mutual of Omaha Plaza, Omaha, NE 68175



## **MEMORANDUM OF COVERAGE**

This Memorandum of Coverage is issued to the Direct Marketers Insurance Trust (“the Policyholder”) under Master Policy SR2014MO-053172.

This Memorandum of Coverage is a legal contract between the Sponsoring Organization and Us. It is issued in consideration of payment of premiums.

The Memorandum of Coverage is issued in and will be interpreted by the laws of the State of Missouri without giving effect to the principles of conflicts of law of that State or any other state. Any part of this Memorandum of Coverage which is in conflict with the laws of the State of Missouri is changed to conform to the minimum requirements of that State's laws.

We agree to pay benefits subject to the terms, conditions, and limitations of this Memorandum of Coverage.

**THIS IS A BLANKET LIMITED ACCIDENT ONLY MEMORANDUM OF COVERAGE.**

**READ IT CAREFULLY.**

**BENEFITS ARE NOT PAYABLE FOR LOSS DUE TO SICKNESS.**

**THIS MEMORANDUM OF COVERAGE IS NOT A MEDICARE SUPPLEMENT POLICY.**

**If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Us.**

## **INSURED RISKS**

Unless otherwise stated in the Schedule, We will pay benefits for a loss only once.

### **SPONSORED AND SUPERVISED ACTIVITY COVERAGE (IRACT068-MO)**

We will pay the benefits in this Memorandum of Coverage for an Insured while:

- participating in a Sponsored and Supervised Activity;
- traveling as part of a group in transportation authorized or arranged by the Policyholder/Sponsoring Organization.

## **ELIGIBILITY FOR BENEFITS**

### **ELIGIBILITY**

Persons who are eligible to be an Insured under this Memorandum of Coverage are described in the Schedule. This includes persons who may become eligible while this Memorandum of Coverage is in force.

### **WHEN INSURANCE BEGINS**

Insurance for an Insured begins on the later of:

- the Effective Date; or
- the day the Insured becomes eligible under the terms of this Memorandum of Coverage.

### **CHANGE IN COVERAGE**

Any change in the Insured's coverage because of change of class as shown in the Schedule will become effective on the date of the change.

### **WHEN INSURANCE ENDS**

Insurance for an Insured will end on the earliest of the date:

- the Insured is no longer eligible;
- the Insured enters full time active duty in any Armed Forces;
- any premium for the Insured is due and unpaid, subject to the Grace Period provision; or
- this Memorandum of Coverage is terminated.

Termination of insurance will not affect a claim incurred while coverage was in effect.

## **DESCRIPTION OF BENEFITS**

### **ACCIDENTAL DEATH AND SPECIFIC LOSS BENEFIT (ADSLPERC001)**

If an Insured suffers a loss listed below from an Accident within the Loss Period stated in the Schedule, We will pay the benefit opposite the Loss. If the Insured sustains more than one loss as the result of one Accident, We will pay only the largest benefit to which the Insured is entitled.

The Principal Sum is shown in the Schedule.

**TABLE OF BENEFITS FOR  
ACCIDENTAL DEATH AND SPECIFIC LOSS**

<i>Loss</i>	<i>Benefit Amount</i>
Loss of Life	100% of Principal Sum
Loss of Both Hands	100% of Principal Sum
Loss of Both Feet	100% of Principal Sum
Loss of Entire Sight of Both Eyes	100% of Principal Sum
Loss of One Hand and One Foot	100% of Principal Sum
Loss of One Hand and Entire Sight of One Eye	100% of Principal Sum
Loss of One Foot and Entire Sight of One Eye	100% of Principal Sum
Loss of Speech and Hearing	100% of Principal Sum
Loss of Entire Sight of One Eye	50% of Principal Sum
Loss of Speech or Hearing	50% of Principal Sum
Loss of One Hand or One Foot	50% of Principal Sum
Loss of Thumb and Index Finger	25% of Principal Sum

**MEDICAL EXPENSE FOR ACCIDENT BENEFIT (AME002-MO)**

We will pay the following Medical Expenses incurred as a result of an Accident. The Medical Expense Maximum and any applicable sub-limit amounts are shown in the Schedule.

1. Hospital room and board charges, up to the average semi-private daily room rate, for each day in the Hospital;
2. Intensive Care Unit charges are payable in lieu of payment for Hospital room and board charges for each day the Insured is confined in an intensive care unit;
3. Hospital miscellaneous charges during a hospital confinement. Miscellaneous charges do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take-home items, or other convenience items;
4. outpatient charges by a Hospital for:
  - a. emergency room treatment. Treatment must be received within 72 hours of the Accident;
  - b. emergency room physician; or
  - c. use of surgical facilities;
5. surgical charges for the primary performance of a surgical procedure by a Physician; subject to the following:
  - a. if bilateral or multiple surgical procedures are performed by one Physician, We will pay the Medical Expenses for the primary procedure;
  - b. for each procedure that is not the primary procedure performed through the same incision as the primary procedure, we will pay 50% of the amount otherwise payable if the additional procedure were the primary procedure;
  - c. if multiple surgical procedures are performed during the same operating session, reimbursement shall be based upon, 100% of Reasonable Allowable Expense for the primary procedure, 50% of Reasonable Allowable Expense for the secondary procedure and 25% of Reasonable Allowable Expense for the third and subsequent procedures;
  - d. any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered incidental and no benefits will be provided for such procedure;
  - e. if multiple unrelated surgical procedures are performed by two or more Physicians on separate operative fields, benefits will be based on the Medical Expenses for each Physician's primary procedure; and
  - f. if two or more Physicians perform a procedure that is normally performed by one Physician, We will only pay the Medical Expenses for the primary Physician;
6. surgical charges for assistant surgeon duties will be reimbursed at 25% of the allowable for surgery codes that have been assigned an assistant surgery indicator by the Centers for Medicare & Medicaid Services;
7. charges for anesthesia and its administration for surgery;
8. Physician's charges for other than pre- or post-operative care for in-Hospital visits or office visits;

9. charges for, including Physician's charges for reading or interpreting the results of, Laboratory Tests and diagnostic imaging including X-Ray, MRI, or CAT Scan;
10. charges for nursing services, other than routine Hospital care, by or under the supervision of a Nurse;
11. treatment of the spine by manual or mechanical means;
12. charges for physiotherapy which includes:
  - a. adjustment;
  - b. diathermy;
  - c. heat treatment;
  - d. manipulation;
  - e. microtherm;
  - f. ultrasonic;
13. Ambulance Service (Surface) and Ambulance Service (Air);
14. Orthopedic Appliances and prosthetics, not including replacements;
15. Prescription Drugs;
16. dental expense for sound natural teeth; and
17. other Medical Expenses as noted in the Schedule.

### **EXCLUSIONS (EXCUS001-MO)**

We will not pay benefits for a loss due to or expenses incurred for:

1. intentionally self-inflicted injury, suicide while sane;
2. voluntary self-administration of any drug or chemical substance not prescribed by or not taken according to the directions of the Insured's Physician;
3. treatment for alcoholism or drug addiction;
4. Injury caused by, attributable to, or resulting from the Insured's Intoxication;
5. Injury caused by, attributable to, or resulting from the Insured's use of a Controlled Substance unless administered on the advice of a Physician and taking the prescribed dosage;
6. operating a motor vehicle under the influence of a Controlled Substance unless administered on the advice of a Physician and taking the prescribed dosage;
7. operating a motor vehicle while having a blood alcohol level that equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the Injury occurred;
8. commitment of or an attempt to commit a felony, or engagement in an illegal activity;
9. participation in a riot or insurrection;
10. any Injury that results from fighting, brawling, assault or battery;
11. an act of declared or undeclared war;
12. active duty service in any Armed Forces;
13. operating, learning to operate, or serving as a pilot or crew member of any aircraft unless specified in the Insured Risk section of this Memorandum of Coverage;
14. mountaineering (engaging in the sport of scaling mountains generally requiring the use of picks, ropes, or other special equipment);
15. parachuting, except for self-preservation;
16. snow skiing, scuba diving, bob-sledding, bungee jumping, ballooning, flight in an ultralight aircraft, sky diving, hang-gliding, glider flying, sailplaning, or parasailing;
17. participation in professional racing;
18. injuries associated with activities or travel outside the United States;
19. sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. This does not exclude bacterial infection that is the natural and foreseeable result of an Injury or accidental food poisoning;
20. orthodontic braces or appliances;
21. any loss for which benefits are paid under state or federal worker's compensation, employers' liability, or occupational disease law;
22. treatment in any Veterans Administration or federal Hospital, unless there is a legal obligation to pay;
23. charges which the Insured would not have to pay if the Insured did not have insurance;
24. a charge which is in excess of the Reasonable Allowable Expense;

25. cosmetic surgery, except reconstructive surgery due to a covered Injury;
26. participation in semi-professional and professional sports, play or practice, or any related travel;
27. organ transplants;
28. elective treatment or surgery that is not prescribed by a Physician and is not Medically Necessary, health treatment, or examination where no Injury is involved;
29. preventive medicines or, serums or, vaccines;
30. voluntary termination of pregnancy;
31. contraceptive methods, devices or aids; elective sterilization or its reversal; artificial insemination; or in-vitro fertilization;
32. routine medical care; and normal health checkups;
33. rest cures or Custodial Care;
34. mental and nervous disorders;
35. Pre-existing Conditions;
36. human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC);
37. infectious disease;
38. any Heart or Circulatory Malfunction;
39. loss caused by or resulting from nuclear radiation or the release of nuclear energy;
40. services or treatment rendered by a Physician, Nurse or any other person who is:
  - employed or retained by the Sponsoring Organization; or
  - the Insured or an Immediate Family Member;
41. services or treatment incurred to the extent that they are paid or payable under any Other Insurance Plan;
42. services or treatment incurred to the extent that they are paid or payable under any automobile insurance policy without regard to fault. This exclusion does not apply in any state where it is prohibited;
43. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any Other Insurance Plan;
44. travel in or upon:
  - a snowmobile;
  - any two or three wheeled motor vehicle;
  - any off-road motorized vehicle not requiring licensing as a motor vehicle in the jurisdiction where operated;
45. any Accident in which the Insured is operating a motor vehicle without a current and valid motor vehicle operator's license (except in a driver's education program);
46. eyeglasses, contact lenses, hearing aids, or related examinations or prescriptions;
47. treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy.

## **TERMS OF BENEFIT PAYMENTS**

We will pay the benefits specified in the DESCRIPTION OF BENEFITS section to all Insureds who suffer a loss within the Scope of Coverage due to Injury.

### **FULL EXCESS MEDICAL EXPENSE (TBFE004)**

We will pay the Medical Expenses an Insured incurs for covered services that exceed amounts payable by any Other Insurance Plan, subject to the Deductible, Benefit Percentage, and Benefit Period shown in the Schedule. We will determine the amount of benefits provided by any Other Insurance Plan without reference to any coordination of benefits, non-duplication of benefits or similar provisions. The amount of benefits provided by an Other Insurance Plan includes any amount to which the Insured is entitled whether or not a claim is made for the benefits. This Memorandum of Coverage is secondary to all Other Insurance Plans.

The first Medical Expense must be incurred within the Loss Period stated in the Schedule.

The Maximum Benefit Amount payable and sub-limits under this Memorandum of Coverage are shown in the Schedule.

## **NON-DUPLICATION OF BENEFITS**

This provision applies if an Insured:

- is covered by any Other Insurance Plan; and
- would, as a result, receive total medical expense or service benefits that would exceed the expenses actually incurred.

In this case, the Medical Expense for Accident Benefit payable under this Memorandum of Coverage will be reduced by the excess amount of benefits. The total amount of benefits payable will never exceed 100% of the Medical Expenses or service benefits.

## **CLAIM PROVISIONS**

### **NOTICE OF CLAIM**

We must receive written notice within 90 days after a loss occurs or begins, or as soon as reasonably possible. Notice can be given at Our home office or to Our authorized representative. Notice should include:

- the Sponsoring Organization's name;
- the Sponsoring Organization group number; and
- the Insured's name and address.

Failure to give notice within this time frame shall not invalidate nor reduce any claim.

### **CLAIM FORMS**

When We receive the notice of the claim, We will send forms for filing proof of loss within 15 days. If We do not send the necessary forms within 15 days, written information may be given that includes the nature, date, cause, and extent of the loss for which claim is made.

### **PROOF OF LOSS**

We must be given written proof of loss at Our home office or to Our authorized representative within 90 days after the date of the loss. If the written proof is not given within 90 days, the claim will not be invalidated or reduced if:

- it was not reasonably possible to give proof within 90 days; and
- proof is given as soon as reasonably possible, but not later than one year from the date it is otherwise required, except in the absence of legal capacity.

If the claim is for a continuing loss for which this Memorandum of Coverage provides periodic payments, written proof that the loss continues must be given to Us or to Our authorized representative at the intervals We require.

### **Physical Examination and Autopsy**

We have the right to have an Insured examined at Our cost and as often as reasonably necessary while the claim is pending. We require an autopsy at Our expense unless prohibited by law.

### **PAYMENT OF CLAIMS**

Benefits will be paid within 30 days after We receive acceptable proof of loss and confirm benefits are payable.

We will pay benefits for loss of life and any benefits payable to the Insured but unpaid at the Insured's death to the Insured's named beneficiary for this Memorandum of Coverage. This choice must be in writing and filed with Us, or filed with the Sponsoring Organization if We have agreed in advance.

The Insured has the right to change the beneficiary. Unless this right has been given up, the Insured does not need the consent of the beneficiary to make a change.

If the Insured has not named a beneficiary or no beneficiary survives the Insured, We will pay benefits at the Insured's death as follows:

- to the Insured's surviving spouse; if none, then



- in equal shares to the Insured's surviving children; if none, then
- in equal shares to the Insured's surviving parents; if none, then
- in equal shares to the Insured's surviving brothers and sisters; if none, then
- to the Insured's estate.

If benefits are payable to a person who is not legally competent to claim or release benefits, a minor, or an estate, We may pay up to \$1,000 to any relative by blood or marriage whom We find entitled to the payment. This good faith payment satisfies Our legal duty to the extent of the payment.

### **Assignment of Benefits**

The Insured may direct that We pay benefits to a Hospital, Physician or other provider who furnished care, diagnosis, advice or supplies. We are not liable for any actions We take before We receive notice of the assignment. We are not responsible for the validity of any assignment of benefits.

### **OPPORTUNITY TO REQUEST AN APPEAL**

The claimant may request an appeal, in writing, within 60 days after receiving notice of Our initial claim review decision.

The request for an appeal should include:

- the Sponsoring Organization's name and the Sponsoring Organization group number;
- the Insured's name and mailing address;
- the name and mailing address of the claimant filing the appeal, if different from the Insured;
- the nature of the appeal; and
- any additional information that may have been omitted from Our review or that We should consider.

By requesting an appeal, the claimant has authorized Us, or anyone We designate, to review any and all records (including, but not limited to, medical records) which We determine may be relevant to the appeal. We will review all information submitted and make Our final determination. No additional appeals are available.

Applicable state laws may contain requirements for claims review and appeal procedures. To the extent that this provision is inconsistent with any state law requirement, the requirement that is most favorable to the claimant will apply.

## **PREMIUM PROVISIONS**

### **REPORTING REQUIREMENTS**

The Sponsoring Organization or its authorized agent must report to Us any additional information required, as We and the Sponsoring Organization agree. We must receive this report before the premium due date.

### **GRACE PERIOD**

There is a 31-day grace period for payment of each premium due after the first premium. This means that, except for the initial premium, if premium is not paid on or before the date it is due, the premium must be paid in the 31-day period that follows. We will consider premium to be paid on the date We receive it.

Insurance will stay in force during the grace period unless the Sponsoring Organization has notified Us of its intention to terminate this coverage during the grace period. If We receive such notice, insurance will terminate on the date requested.

If We have not been notified otherwise and the premium has not been paid, this Memorandum of Coverage will end on the date premium was due.

## **CHANGES IN RATES**

We have the right to change the premium rates:

- at any time there is a change in the coverage provided or classes eligible;
- at any time there is a change in the risks We have assumed; or
- after the first 12 months insurance is in effect.

New rates based on coverage or eligibility changes will take effect on the effective date of those changes. Otherwise, we will give 31 days written notice when we change the rates. Notice will be sent to the Sponsoring Organization's most recent address in Our records.

## **REINSTATEMENT AFTER TERMINATION**

If this Memorandum of Coverage terminates for any reason, the Sponsoring Organization may request to reinstate it. We will reinstate only if:

- an authorized representative in Our home office agrees in writing to reinstate this Memorandum of Coverage;
- the Sponsoring Organization agrees in writing to accept any written conditions of reinstatement that We impose;
- all past due premiums are paid, including any premium for the time insurance was in effect during the grace period; and
- the premium due from the date of reinstatement until the next premium due date is paid.

## **GENERAL PROVISIONS**

### **INSURANCE CONTRACT**

This insurance contract consists of:

- this Memorandum of coverage;
- the attached Schedule; and
- any riders or endorsements.

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time We and the Sponsoring Organization both agree to a change, unless required by law. No one else has the authority to change the insurance contract. A change in the insurance contract must be:

- in writing;
- made a part of this Memorandum of Coverage; and
- signed by Our authorized representative in Our home office.

### **WORKERS COMPENSATION INSURANCE**

This Memorandum of Coverage does not satisfy any requirement for coverage under any workers compensation law.

### **SPONSORING ORGANIZATION RECORDS**

The Sponsoring Organization or its authorized administrator will maintain records of the essential features of each Insured's insurance under this Memorandum of Coverage y.

We have the right to examine the Sponsoring Organization's records relating to coverage under this Memorandum of Coverage. Examination may occur at any reasonable time up to the later of:

- two years after this coverage ends; or
- the date of final adjustment and settlement of all claims under this coverage.

## **TERMINATION**

We may terminate this coverage on or after the first anniversary. We will give at least 60 days notice before termination.

The Sponsoring Organization may terminate this coverage at any time. If the Sponsoring Organization fails to pay premiums when due or within the grace period, We will consider notice to have been given to terminate this coverage on the date premium was due.

We will refund any unearned premium from the date of termination.

Coverage termination will not affect a claim for a loss due to an Accident that occurred while this Memorandum of Coverage was in effect.

## **INCONTESTABILITY**

We will not contest this Memorandum of Coverage after it has been in force two years, except for nonpayment of premium.

All statements made by the Sponsoring Organization to obtain this Memorandum of Coverage are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Memorandum of Coverage unless a copy of the instrument containing the statement is, or has been, furnished to the Sponsoring Organization. After two years from the Effective Date, no such statement will cause this Memorandum of Coverage to be contested except for fraud.

## **CONFORMITY WITH STATE STATUTES**

Any provision of this Memorandum of Coverage in conflict with the laws of the state where it is issued on the Effective Date is amended to conform to the minimum requirements of such laws.

## **LEGAL ACTIONS**

No legal action to recover under this Memorandum of Coverage can be brought for at least 60 days after We have been given written proof of loss. No legal action can be brought after three years from the time written proof of loss is required to be given to Us.

## **DEFINITIONS**

The following capitalized terms have the meaning assigned to them in this section. The assigned definitions apply to both the singular and plural forms of the defined term.

*Accident* means an unexpected and unintended event, independent of sickness and all other causes, which:

- causes Injury to an Insured; and
- occurs within the Scope of Coverage.

*Ambulance Service (Air)* means the service provided:

- by means of a fixed or roto-winged aircraft equipped with life support and medical apparatus; and
- for the primary purpose of transporting an Insured to or from the Hospital where treatment is given.

*Ambulance Service (Surface)* means the service provided:

- by a commercial or municipal ground ambulance service; and
- for transporting an Insured to or from the Hospital where treatment is given.

*Ambulatory Surgical Center* means a surgical or medical center which:

- has permanent facilities for surgery;
- has an organized medical staff of Physicians and graduate registered nurses (R.N.);
- is authorized by law in the jurisdiction in which it is located to perform surgical services; and
- is licensed (if no license is required, officially approved) under the law.

*Benefit Period* means the period of time, as stated in the Schedule, from the date of the Injury within which benefits will be paid.

*Controlled Substance* means any drug or substance, other than alcohol, having the capacity to affect behavior and that is regulated by law with regard to possession and use.

*Deductible (Corridor)* means the amount of eligible Medical Expenses incurred by an Insured for each loss before benefits are payable under this Memorandum of Coverage. It applies separately to each Insured and each Injury.

*Heart or Circulatory Malfunction* means an acute onset of a cardiovascular or circulatory accident, stroke or other similar traumatic event affecting the heart or circulatory system:

- which is first diagnosed and treated while the Insured's coverage under this policy is in force;
- which occurs as a result of Injury to the Insured while participating in a Sponsored and Supervised Activity; and
- which does not result from a Pre-Existing Condition.

*Hospital* means an institution which:

- is operated pursuant to law;
- has organized facilities for the care and treatment of sick and injured persons on a resident of inpatient basis;
- is under the supervision of a staff of one or more Physicians;
- provides 24-hour nursing service by registered nurses on duty or call; and
- has medical, diagnostic and treatment facilities, with surgical facilities on its premises or available to it on a prearranged basis.

Hospital does not include:

- a clinic or facility exclusively for:
  - convalescent, nursing, rest or extended care;
  - the treatment of the aged, drug addicts or alcoholics;
  - rehabilitation; or
- a military or veterans hospital or a hospital contracted for or operated by a national government or its agency unless:
  - the services are rendered on an emergency basis; and
  - the individual has a legal liability to pay for the services given in the absence of insurance.

*Immediate Family Member* means a spouse or a child, parent, grandparent, brother or sister of the Insured, step-relatives in these same categories, or a person who reared the Insured, or a person whom the Insured reared.

*Injury* means bodily harm which:

- requires treatment by a Physician;
- results in loss due to an Accident, independent of sickness and all other causes; and
- occurs within the Scope of Coverage.

Bodily harm does not include a Pre-Existing Condition.

*Insured* means a person:

- who is eligible for insurance under the terms of the Memorandum of Coverage; and
- for whom proper premium has been paid.

*Intensive Care Unit* means a section, ward, or wing within a Hospital which is separated from other Hospital facilities and:

- is operated exclusively for the purpose of providing professional treatment for critically ill or Injured patients;
- has special supplies and equipment necessary for such treatment which is available on a standby basis for immediate use;
- provides room and board, and constant observation by registered graduate nurses or other specialty trained Hospital personnel; and
- is not maintained for the purpose of providing normal post-operative recovery treatment or service.

*Intoxicated, intoxication* means the Insured's condition as determined and defined by the laws in the jurisdiction in which the loss or cause of loss was incurred; (for the purposes of this exception, the laws governing the operation of motor vehicles while intoxicated will apply to any activity occurring at the time of the accident.)

*Laboratory Tests* means laboratory procedures identified in Physician Current Procedural Terminology (CPT) as codes 80000- 89999 inclusive.

*Loss of a Foot* means Severance above the ankle.

*Loss of a Hand* means Severance at or above the wrist.

*Loss of Hearing* means total and permanent loss of hearing which cannot be corrected by any means.

*Loss of Sight* means the total, permanent loss of sight of the eye or eyes. The loss of sight must be irrecoverable by natural, surgical or artificial means.

*Loss of Speech* means total, permanent and irrecoverable loss of audible communication.

*Loss of a Thumb and Index Finger* of the same hand means Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand) from the same Accident.

*Loss Period* means the period of time stated in the Schedule from the date of an Accident within which the Insured must seek initial treatment for an Injury or death or Specific Loss must occur.

*Maximum Benefit Amount* means the total benefits payable under an applicable benefit provision. The Maximum Benefit Amount is shown in the Schedule.

*Medical Expenses* means expenses incurred for Medically Necessary services and supplies. Medical Expenses are incurred on the date the service or supply is rendered or provided.

*Medically Necessary, Medical Necessity* means care that is ordered, prescribed, or rendered by a Physician or Hospital, and is determined by Us, or a qualified party or entity selected by Us, to be:

- consistent with the diagnosis and treatment of the loss;
- appropriate with the standards of good medical practice;
- not solely for the convenience of the Insured;
- the most appropriate supply or level of service which can be safely provided; and
- not considered experimental or investigative.

*Nurse* means a professional, licensed, graduate registered nurse (RN), a professional, licensed practical nurse (LPN) or a certified registered nurse anesthetist (CRNA).

*Nurse Practitioner* means a licensed registered nurse who has received special training for diagnosing and treating routine or minor ailments.

*Orthopedic Appliances* means braces and appliances that:

- are prescribed by a Physician;
- are primarily and customarily used to serve a medical purpose;
- can withstand repeated use; and
- are Medically Necessary.

*Other Insurance Plan* means any contract, Memorandum of Coverage or other arrangement for benefits or services for medical or dental care or treatment under:

- any individual, group, blanket, or franchise policy of accident, disability, or health insurance;
- any arrangement of benefits for members of a group, whether insured or uninsured;

- any prepaid service arrangement such as Blue Cross or Blue Shield, individual or group practice plans, or health maintenance organizations;
- any amount payable for Hospital, medical, or other health services for Injury arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used including such benefits mandated by law) of any motor vehicle insurance policy;
- any amount payable for services for injuries or diseases related to the Insured's job to the extent that the Insured actually receives benefits under a workers compensation law. If the Insured enters into a settlement to give up the Insured's rights to recover future medical expenses under a workers compensation law, this Memorandum of Coverage will not pay those medical expenses that would have been payable except for that settlement; or
- any benefits payable under any program provided or sponsored solely or primarily by any federal, state, or local governmental unit or agency or subdivision or through operation of law or regulation, except Medicaid and Tricare.

*Outpatient Surgical Center* means a surgical or medical center which has:

- permanent facilities for surgery;
- organized medical staff of Physicians and Nurses; and
- is authorized by law in the jurisdiction in which it is located to perform surgical services and is licensed (if no license is required, officially approved) under law.

*Physician* means a legally qualified physician, Nurse Practitioner or Physician's Assistant practicing within the scope of his or her license; and recognized as a physician in the state where services are rendered. Physician does not include:

- the Insured; or
- an Immediate Family Member; or
- a person living with the Insured; or
- a person employed or retained by the Sponsoring Organization.

*Physician's Assistant (PA)* means a medical professional, other than the Insured, who is trained and licensed to provide basic medical services under the direction of a Physician.

*Pre-Existing Condition* means any condition for which an Insured has received care, diagnosis or advice from a Physician or of which symptoms were manifested within 12 months before being covered by this policy.

*Prescription Drugs* means drugs which:

- under Federal law may only be dispensed by written prescription; and
- are approved for general use by the Food and Drug Administration.

*Reasonable Allowable Expense* means a Medical Expense otherwise payable under the Memorandum of Coverage that is not in excess of the 80<sup>th</sup> percentile identified on Context4HealthCare (the "Database"). When there is, in Our determination, minimal data available from the Database for a Medical Expense, We will determine the amount to pay by calculating the unit cost for the applicable service category using the Database and multiplying that by the relative value of the Medical Expense based upon a commercially available relative value scale selected by Us. In the event of an unusually complex medical procedure, a Medical Expense for a new procedure or a Medical Expense that otherwise does not have a relative value that is in Our determination applicable, We will assign a relative value. The Medical Expenses We pay may not reflect the actual charges of a provider and does not take into account the provider's training, experience or category of licensure. A provider may charge the Insured the difference between what the provider charges and the amount We pay under the Memorandum of Coverage. The Database will be updated by us as information becomes available from the supplier, up to twice each year. We may modify the Database in Our discretion to reflect Our experience. We have the right, in Our discretion, to substitute or replace the Database with another database or databases of comparable purpose, with or without notice.

*Scope of Coverage* means insurance coverage limited to a loss which:

- is within the scope of the risks specified in the INSURED RISKS section of this Memorandum of Coverage;
- is specified in the DESCRIPTION OF BENEFITS section of this Memorandum of Coverage;
- occurs during the Loss Period for the loss incurred specified in the Schedule, if any; and
- occurs while this Memorandum of Coverage is in effect.

*Severance* means the complete and permanent separation and dismemberment of the part from the body.

*Sponsored and Supervised Activity* means a Sponsoring Organization authorized function:

- in which the Insured participates;
- which is organized by or under its auspices and sanctioned by the appropriate governing authority; and
- which is within the scope of customary activities for such entity.

*Sponsoring Organization* means a legal entity to whom this Memorandum of Coverage is issued or that elects coverage under this Memorandum of Coverage.

*We, Our, Us* means Mutual of Omaha Insurance Company.

*X-ray* means those procedures identified in Physician Current Procedural Terminology (CPT) as codes 700