CATHOLIC MUTUAL GROUP
Commitment. Expertise. Stability.

Date: August 1st, 2026

To: Principals, Business Managers of Schools/Parishes, & Preschool Directors Participating in the Archdiocese of Atlanta Student, Camp & Sports Accident Insurance Programs

From: Jordan Harper, Claims/Risk Manager

Re: 2026/2027 – Updated Student, Camp & Sport Accident Coverage Claim Instructions

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The Archdiocese of Atlanta has placed Student Accident Coverage with Zurich for student, camp & sport injuries.

Please be advised that effective 8/1/2026, the new claims administrator for Student Accident Insurance claims is **BMI Claims**.

Enclosed please find claim filing instructions for **BMI Claims**. It is critical that all schools/parishes complete Part 1A of the BMI Student Accident Claim Form and provide it, along with the BMI Student Accident Claims Instructions Guide, to the parent(s)/guardian(s) immediately following a student injury. The parent(s)/guardian(s) are then responsible for completing Part 1B of the BMI Student Accident Claim Form and following the BMI Claims Student Accident Instructions Guide to submit and have their claim processed.

These instructions can also be found at https://resources.archatl.com/business/insurance/

The Archdiocese of Atlanta is happy to provide this coverage for the protection of your student body. If there are any questions, please do not hesitate to contact the undersigned.

Sincerely,

Jordan Harper | Claims/Risk Manager
Catholic Mutual Group | 2401 Lake Park Drive SE, Smyrna, GA 30080
W| (404) 920-7377
F | (402) 551-2943
jharper@catholicmutual.org

BMI Benefits, LLC.
P.O. Box 511
Matawan, NJ 07747
Phone: 800.445.3126
Fax: 732.583.9610
Email: BMI@bobmccloskey.com
www.bobmccloskey.com

Student Accident Insurance Claim Filing Checklist

PLEASE NOTE – THIS POLICY IS SECONDARY TO PARENTAL/GUARDIAN MEDICAL/DENTAL INSURANCE. THERE ARE SPECIFIC REQUIREMENTS AND SPECIFIC DOCUMENTS NEEDED IN ORDER FOR A CLAIM TO BE PROCESSED AND PAID UNDER THIS POLICY. PLEASE REVIEW THE CLAIMS PACKET IN ITS ENTIRETY. THE SCHOOL/PARISH IS NOT RESPONSIBLE FOR CLAIMS AND/OUT OUT-OF-POCKET EXPENSES WHERE THE PARENT(S)/GUARDIAN(S) DID NOT FOLLOW THE STUDENT ACCIDENT INSTRUCTIONS, DID NOT FILE THEIR CLAIM TIMELY, AND/OR EXPENSES INCURRED THAT ARE NOT COVERED BY THE STUDENT ACCIDENT INSURNACE POLICY.

If Parent(s)/Guardian(s) have primary health coverage, they must go to a physician in their Insurance's Preferred Provider Network.

☐ School – Complete Part 1A of the BMI Benefits Accident/Injury Claim Form.

☐ Parent/Guardian – Complete Part 1B and Parent/Guardian Information Sections of the Accident Claim Form

i. If student/claimant has NO medical/dental coverage, please indicate under Part 1B of the Claim form and complete the Statement of No Other Insurance Document which is included in this packet. ONLY Complete statement of no other insurance if you have no other insurance.
ii. **Please notify all health care providers that you have secondary coverage for the accident/injury.** You should provide them with a copy of the provider letter (enclosed) and instruct the provider to bill BMI Benefits directly after primary insurance has processed the claim. It is still your responsibility to file the accident claim form directly with BMI Benefits.

☐ Submit completed and signed accident claim form to BMI Benefits, LLC. Please retain a copy for your records.

BMI Benefits, LLC.
PO Box 511
Matawan, NJ 07747
Fax: 732.583.9610
Email: doreenb@bobmccloskey.com

☐ See Claim Filing Instructions page for additional information. You will have medical claims/bills to submit to BMI for payment. We recommend NOT paying any bills upfront, but to allow BMI to process the medical claim/bill and we will pay the medical provider directly. BMI will NOT be able to process and pay claims based on balance due statements. The insurance requires itemized bills and primary insurance Explanation of Benefit (EOBs), if applicable, to be submitted for any covered claim to be processed and paid. **We recommend that you contact the medical providers and provide the BMI information as the secondary insurance so the provider can bill BMI directly with the required insurance documents.** If you paid a bill out of pocket, we would need the receipt or statement of account showing payment, **along with the itemized bill and primary EOBs.** See the enclosed materials for additional information.

Enclosed Documents

Provider Letter with Insurance Information Card
Statement of No Other Insurance
Summary of Coverage
Claim Instructions
Claim Frequently Asked Questions (FAQ)
Sample Itemized Bills
Program Summary of Coverage (Zurich)

If Parent(s)/Guardian(s) have primary health coverage, they must go to a physician in their Insurance's Preferred Provider Network.

Student Accident Claim Form

BMI Benefits, LLC.
P.O. Box 511
Matawan, NJ 07747
Phone: 800.445.3126
Fax: 732.583.9610
BMI@bobmccloskey.com
www.bobmccloskey.com

Please complete this form in its entirety and submit to BMI Benefits within 90 days from the date of accident. Please retain a copy for your records. **Please contact the medical/dental providers where treatment was received, submit BMI's billing information as your secondary insurance, and ask for BMI to be billed directly.** You should provide them with a copy of this form. You may also obtain from the medical/dental providers **all itemized bills** and **primary insurance explanation of benefits (EOBs)**. Itemized bills are considered **HCFA1500** Forms (physician's office), **UB-04** Forms (hospitals), and **ADA Dental Claim Forms** (dentist) **not balance due statements.** Please reference the attached claims instruction document for additional information. BMI Benefits here in referred to as "Administrator"

PART 1A - POLICYHOLDER

School/Organization/Policyholder Name / Individual School Location/Name	Policy#
Archdiocese of Atlanta	MCB-5465806

School/Organization/Policyholder Mailing Address (Street, City, State, Zip)

Student's Name	Date of Birth	Male ◯ Female ◯

Date of Injury	Time	Name of Activity or Sport Type	Body Part Injured	◯ Left Body Part ◯ Right Body Part

At the time of the accident, was the student involved in an activity sponsored and supervised by the Policyholder? ◯ YES ◯ NO

Sport/Activity Situation: ◯ Game ◯ Practice ◯ Conditioning ◯ Travel ◯ PE ◯ Recess ◯ Classroom ◯ Cafeteria ◯ Club ◯ Bus

How did Injury occur?

Name of School Official:	Title of School Official:

Signature of Supervisor/Official	Date

NOTE: Part 1A – Policyholder section must be signed by an official of the policyholder or the claim cannot be processed

PART 1B - INJURED PERSON INFORMATION & INSURANCE INFORMATION

Student's Last 5 Digits of Social Security Number (Must be provided as required by the Center for Medicare Services)

Student's Home Address (Street, City, State, Zip)

Is the Student covered by any other insurance policy, either as a dependent, or under a group, individual, automobile, medical or liability Policy? **YES** ◯ **NO** ◯ If Yes, Name of Ins. Carrier: _____ Policy #: MCB-5465806

Is the above insurance a Medicaid Plan or a Military Insurance such as Tricare? **YES** ☐ **NO** ☐

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name		Parent/Guardian Name	
Phone	E-Mail	Phone	E-Mail
Is the Parent/Guardian Employed?	YES ◯ NO ◯	Is the Parent/Guardian Employed?	YES ◯ NO ◯

Authorization to Release Medical Information: I hereby authorize any licensed physician; medical practitioner; hospital; clinic or other medical facility; insurance company; employer; Medical Information Bureau; Motor Vehicle Administration or other organization; or persons that have any records or knowledge of me or my physical or mental health condition to give the underwriting company with which it works, its authorized Administrator or their legal representative, and any agent acting on their behalf any such information. I understand that I may revoke this authorization at any time by providing written notice to the underwriting company or its authorized Administrator. I understand that I may revoke this authorization except to the extent that action has already been taken based upon this authorization. The revocation may not take effect before the date received by the underwriting company or its authorized Administrator. A photocopy of this authorization shall be as valid as the original. This authorization shall be valid for 24 months from the date below (In AZ, CA, CT, GA, HI, IL, ME, MA, MN, NV, NC, NJ, NM, OH, and VA authorization shall be valid during the duration of the claim. In WI, authorization is valid during the duration of the claim or 24 months, whichever is longer). I acknowledge that I, or my authorized representative, am entitled to receive a copy of this authorization upon request. I understand that the authorized Administrator may condition payment of a claim upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed pursuant to this Authorization, the information will remain protected by the authorized Administrator in accordance with federal or state law. Payments will be made to the providers of service unless a paid receipt/statement accompanies the medical claim submission. **Warning:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. (Fraud language varies by state, for New York see the following, all other state specific states, please see below) **For residents of New York**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Claimant or Authorized Person's Signature	Date

FRAUD WARNING NOTICES

For residents of Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
For residents of Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
For residents of California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
For residents of Delaware and Idaho: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.
For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
For residents of Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
For residents of Kansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.
For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
For residents of Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
For residents of Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
For residents of New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.
For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
For residents of New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTYOF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
For residents of Ohio and Oklahoma: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
For residents of Oregon: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.
For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
For residents of Vermont: Any person who knowingly presents a false statement in a claim for proceeds of an insurancepolicy may be guilty of a criminal offense and subject to penalties under state law.

BMI Benefits
FULL TPA SERVICES

Student Accident Insurance

Provider Letter & Insurance Information Card

To: Medical Provider

From: BMI Benefits, LLC.

Subject: Excess Student Accident Insurance

To Whom It May Concern:

The School or School District carriers an excess student accident insurance policy which insures students when medical claims are incurred as the result of a covered accident or injury.

The insurance policy is through Bob McCloskey Insurance and BMI Benefits, LLC. You should not collect any payment from the student at the time of service. Any primary insurance deductible amount/copay amount will be eligible to be submitted under the policy with BMI, and will be processed according to the policy terms, conditions, benefits and limitations.

The itemized bills (HCFA 1500, UB04 or ADA Dental) along with the primary E.O.B.(if there is primary insurance) should be submitted directly to BMI. At any time, you can contact BMI Benefits for student eligibility, benefits, or status questions at 800.445.3126.

Sincerely,

BMI Benefits
P.O. Box 511 | Matawan, NJ 07747
Phone: 800.445.3126
Fax: 732.583.9610
BMI@bobmccloskey.com
www.bobmccloskey.com

INSURANCE INFORMATION CARD

Policy #: MCB-5465806

Group #: Archdiocese of Atlanta

CLAIM FILING INSTRUCTIONS

Coverage under this policy is Excess of all other insurance and claims must first be submitted to any other insurance. Initial medical treatment must be incurred within 90 days from the date of the accident. Claims must be submitted to BMI Benefits LLC within 90 days after the date of treatment. Mail, Fax or E-Mail all medical bills and primary insurance statements showing payment or rejection, please include the name of the insured and the name of the school that the student attended to:

BMI Benefits, LLC
P O Box 511, Matawan, NJ 07747
Phone: 800-445-3126
Fax: 732-583-.9610
E-Mail: BMI@bobmccloskey.com

BMI Benefits
FULL TPA SERVICES

BMI Benefits, LLC.
P.O. Box 511
Matawan, NJ 07747
Phone: 800.445.3126
Fax: 732.583.9610
Email: BMI@bobmccloskey.com
www.bobmccloskey.com

Got You Covered

Statement of No Other Insurance

Please complete this form in its entirety and submit to BMI Benefits, LLC along with the completed accident claim form ONLY IF you have no other insurance

Insured Name: _____

School/Policyholder Name: _____

Date of Accident: _____

I declare that I was not covered by any other insurance policy, through myself, my parents, or my guardian, for the accident dated above. Should any insurance become effective during my treatment I will notify BMI Benefits and forward all eligible bills to the other insurance carrier. I understand the coverage through BMI Benefits is excess to all other insurance and will pay after all collectible insurance has adjudicate my claims. I understand that if any of these statements are false it could deem my claim ineligible.

_____ _____
(Insured Name or Parent Name if insured is a minor) (Date)

_____ _____
(Insured Signature or Parent Signature if insured is a minor) (Date)

Fraud Warning:
Any person who knowingly and/or with intent to injury, defraud or deceive an insurance company or other person, files a statement of claim containing false, incomplete or misleading information may be guilt of insurance fraud and subject to criminal and substantial civil penalties.

BMI Benefits, LLC.
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Phone: 800.445.3126
Fax: 732.583.9610
Email: BMI@bobmccloskey.com
www.bobmccloskey.com

Student Accident Insurance Claim Filing Instructions

1. **BMI Benefits Accident/Injury Claim Form:** Part 1A must be completed and signed by the school/policyholder. All other sections must be completed by the parent/guardian. If you are employed, but do not have insurance, please state "NO INSURANCE" and complete the enclosed form – 'Statement of No Other Insurance'. Otherwise, our office may submit an insurance questionnaire to your employer to be used as verification of no dependent coverage.

2. **Please contact all medical providers where treatment was received and instruct them that you have secondary insurance. If you give the medical/dental provider a copy of the BMI Accident Claim Form and the Provider Letter, they should bill BMI directly after they bill your primary health insurance. You may also obtain and attach copies of your primary carrier's Explanation of Benefits (EOB) and all itemized medical bills, known as HCFA 1500s (physician billing form), UB-04s (hospital billing form) and ADA Dental Claim Form (dentist billing form) The itemized medical bills should show the ICD-10 and CPT codes for the services provided, as well as other necessary information for insurance processing. Balance due statements are NOT itemized bills and cannot be processed and paid by BMI Benefits. The insurance policy is an excess insurance, which means benefits are provided after any other valid and collectible insurance has processed the medical claims.**

3. In regard to claims for a dental injury, the policy will cover accidental injury to sound, natural teeth. The claim must be submitted to **both** the dental insurance and the medical insurance if available. In regards to reimbursement for prescription expenses, we will need a copy of the itemized prescription bill. Cash register receipts only will not suffice.

4. If you have already paid the medical service provider and wish to be reimbursed directly, please attach a paid receipt or statement that verifies the payment along with the itemized bills and primary EOBs. HSAs and FSAs are reimbursable, however HRAs are not reimbursable.

5. Submit the completed claim form, itemized bills and primary insurance Explanation of Benefits to BMI Benefits, LLC. Claims can be submitted via mail, fax, or e-mail.

FAX	MAIL	E-MAIL
732-705-6389	**BMI Benefits, LLC PO Box 511 Matawan, NJ 07747**	**doreenb@bobmccloskey.com**

6. You may contact BMI Benefits, LLC at 800.445.3126 x 56389 or doreenb@bobmccloskey.com to discuss your claim.

   Please be aware that settlement of your claim may take several weeks to process. When contacting BMI Benefits, please have your claim form available, as well as the name of the school, school district, or Policyholder to ensure prompt assistance.

NOTE: When BMI processes a submitted claim, an Explanation of Benefits (EOB) will be mailed to the medical provider of service with any check payment. A second copy is also mailed to the address on file for the claimant/ student explaining the claim payment details. If any information is missing in order for BMI to process and pay an outstanding claim, an EOB will be mailed stating what needs to be submitted to BMI for reprocessing and payment of the medical claim. All submitted claims are subject to the policy terms, conditions and benefits as outlined in the coverage selected by the Policyholder.

If Parent(s)/Guardian(s) have primary health coverage, they must go to a physician in their Insurance's Preferred Provider Network.

BMI Benefits, LLC.
P.O. Box 511
Matawan, NJ 07747
Phone: 800.445.3126
Fax: 732.583.9610
Email: BMI@bobmccloskey.com
www.bobmccloskey.com

Student Accident Insurance Frequently Asked Questions

Why is my child's school providing student accident insurance?
Many health insurance plans have high deductibles and plan limits that leave parents with high bills resulting from an unexpected accident. This excess policy, provided by the school, protects students and families from the costs associated with school-time and/or sports related accidents depending on your school's chosen policy coverage.

Who is BMI Benefits?
BMI Benefits, LLC. is the claims administrator on behalf of the insurance carrier.

Does primary insurance always have to pay first?
Yes. Medical claims must always be submitted initially to your primary insurance policy. Any remaining balance of expenses not covered by your primary will be submitted to the excess policy. The policy will cover the remaining balance of eligible expenses up to the plan maximum.

Does the accident insurance policy pay for out-of-pocket expenses such as co-pays and deductibles?
Yes. These charges can be submitted to the accident insurance policy to provide reimbursement.

What documents are needed to process a claim?
If your student is involved in a school-related accident, the following documents are needed to properly process a claim:

- **Fully completed BMI Benefits Accident Claim Form**
- **Itemized Bill – <u>in the form of a HCFA, UB04 or ADA Dental Claim</u>**. These can be obtained through the medical/dental provider. **DO NOT SEND** cash receipts, balance due, balance forward, or past due statements for claims processing or payment. An itemized bill (HCFA or UB04) contains the following information:
  - Provider's Name, Provider's Address, Tax ID Number
  - Date(s) of Service, Type of Service(s) Rendered including CPT and ICD-9 Codes
  - The Fee for Each Procedure
- **Primary Insurance Explanation of Benefits (EOB)** – you should receive a copy of this from your primary insurance carrier. If your health insurance coverage is a state or federal government funded plan such as a Medicaid, Medicare, or Military insurance such as Tri-Care, the primary EOB is not required.

Where do I send all of these documents?
Please send all claim forms, itemized bills, primary EOBs, other insurance information and claims correspondence to BMI Benefits, LLC. **It will be easier to contact your medical provider, submit BMI's information as the secondary insurance, and the provider will bill BMI directly with the itemized bills and primary EOBs.**

What insurance information do I have to give a provider? What is the policy # and Group #?
When you go to hospital, Doctor's office, PT clinic, etc, you must remember to tell them you have secondary insurance through your school's student accident medical insurance policy. Instruct the provider to bill your primary insurance first and then send the primary EOB and the itemized bill to BMI Benefits, LLC**. If you did not submit the secondary insurance information upon your first visit, please call the provider and give them the secondary insurance information for BMI Benefits.** If the provider bills the school's student accident insurance policy directly, this should prevent a balance due statement from being sent to the student/parent. **Policy ID #: Student Initials & DOB (IE: TAM 1212002) Group #: School Name**

What can cause a delay in processing and paying a claim?
The claims administrator cannot process a claim that is missing one or more of the following documents: the accident/injury claim form, the Itemized Bill or the Primary EOB / denial. We cannot accept balance due, balance forward, or past due statements for claims processing.

Who can I contact if I have any questions? If you have questions after you submit your claims to BMI Benefits, LLC. please contact them at 800-445-3126 or BMI@bobmccloskey.com. Please be aware that settlement of your claim may take several weeks to process. When contacting BMI Benefits, please have your claim form available, as well as the name of the school, school district, or Policyholder to ensure prompt assistance.

NOTE: When BMI processes a submitted claim, an Explanation of Benefits (EOB) will be mailed to the medical provider of service with any check payment. A second copy is also mailed to the address on file for the claimant/student explaining the claim payment details. If any information is missing in order for BMI to process and pay an outstanding claim, an EOB will be mailed stating what needs to be submitted to BMI for reprocessing and payment of the medical claim.

ITEMIZED BILL FOR PHYSICIAN BILLING - HCFA 1500 FORM

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

ITEMIZED BILL FOR HOSPITAL & FACILITY CHARGES - UB04 FORM

1	2	3a PAT. CNTL #		4 TYPE OF BILL
		b. MED. REC. #		
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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22									22
23		PAGE ____ OF ____	CREATION DATE		TOTALS				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							57	A
B							OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A					
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			

66 DX	67 I	A J	B K	C L	D M	E N	F O	G P	H Q	68

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI				73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS		81CC			
		a			
		b			
		c			
		d			

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

UB-04 CMS-1450 APPROVED OMB NO.

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC National Uniform Billing Committee

LIC9213257

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F	15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number	17. Employer Name	

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)	22. Gender ☐ M ☐ F	23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "**A**") A _____ C _____ B _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")	39. Enclosures (Y or N) ☐
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)	41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment	43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) / 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)	47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI	50. License Number	51. SSN or TIN
52. Phone Number ( ) -	52a. Additional Provider ID	

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI	55. License Number
56. Address, City, State, Zip Code	56a. Provider Specialty Code
57. Phone Number ( ) -	58. Additional Provider ID

The Roman Catholic Archdiocese of Atlanta

Student & Participant Accident Insurance Plan • MCB 5465806

The following is a brief description of the Student & Participant Accident Insurance Plan. The benefits described are subject to certain limitations and exclusions as described in the policy. For specific definitions of terms used below as well as further details and information about this Plan, please see the policy.

Eligibility

Class I: All enrolled Students and all enrolled Day Care, Pre-School and Extended Care Participants of the Policyholder.

Class II: All registered Non-Student Afterschool Recreation Program Participants and registered Non-Student Summer Camp Participants of the policyholder.

Covered Activities

Class I:

i) All Sports (including Football) Accident Coverage: While participating in a sport and/or activity that is sponsored and supervised by the Policyholder. This includes related practice sessions and on- and off- season physical conditioning. This also includes coverage while traveling directly and uninterruptedly to or from the above in a vehicle designated by the Policyholder.

ii) School Time Accident Coverage: While enrolled as a student with the Policyholder during the hours and on the days when the Policyholder is in session, or during the hours and on the days when the Policyholder is not in session, while participating in a Policyholder sponsored and supervised activity. This includes coverage while traveling directly and uninterruptedly to or from the above in a vehicle designated by the Policyholder.

Class II: While participating in a sport and/or camp activity that is sponsored and supervised by the Policyholder, including football. This includes related practice sessions and on- and off-season physical conditioning. This also includes coverage while traveling directly and uninterruptedly to or from the above in a vehicle designated by the Policyholder.

Benefit Amount

Accidental Death Benefit: $15,000

Accidental Dismemberment Benefit: $30,000

Exposure and Disappearance Benefit: $15,000

Heart Failure Benefit: $15,000

Accidental Excess Integrated Medical Expense Benefit: ..... $25,000 maximum benefit
$0 deductible per insured per covered accident
100% our share of usual and customary expenses per insured per covered accident

Benefit sublimits for the following Covered Medical Services:

Benefits based on a "per Insured per Covered Accident" basis, except where noted

1. Hospital Room/Boarding 100%
2. Ancillary or Miscellaneous Inpatient Hospital 100%
3. Medical Emergency Care 100%
4. Outpatient Surgical Room 100%
5. Diagnostic X-Rays $1,000
6. Laboratory Tests $1,000
7. Physician's Non-Surgical Treatment 100%
8. Physician's Surgical Procedures $1,000
9. Anesthesiologist 100%
10. Registered Nurse 100%
11. Inpatient and Outpatient Physiotherapy ..... $2,000 (Limit 20 visits per Insured)
12. Radiological Procedures $1,000
13. Diagnostic Imaging 100%
14. Ambulance Expenses 100%
15. Rehabilitative Limb Braces, Wheelchairs and other Medical Equipment/Appliances $1,000
16. Eyeglasses, Contacts or Hearing Aids $500
17. Prescription Drugs 100%
18. Accidental Dental 100%

Benefits Provided

Accidental Death Benefit $15,000

If you suffer a loss of life as a result of a covered injury, we will pay the applicable amount shown in the policy schedule. Your death must occur within 365 days of your covered injury.

Accidental Dismemberment Benefit..... The Benefit Amounts Below are based on Your Principal Sum of $30,000

If your covered injury results in any of the following covered losses, we will pay the percentage shown below. Your covered loss must occur within 365 days of your covered accident.

The benefit amount is based on the maximum amount shown in the policy schedule for the person suffering the Covered Loss.

Covered Loss of:	Benefit Amount	Covered Loss of:	Benefit Amount
Both hands or both feet.....	**100% of Principal Sum**	Speech or Hearing.....	**50% of Principal Sum**
One hand and one foot.....	**100% of Principal Sum**	One hand, one foot, or sight of one eye	**50% of Principal Sum**
One hand or one foot plus loss of sight of one eye.....	**100% of Principal Sum**	Thumb and index finger of the same hand	**25% of Principal Sum**
Sight of both eyes	**100% of Principal Sum**	Hearing in One Ear	**25% of Principal Sum**
Speech and Hearing.....	**100% of Principal Sum**		

For purposes of this Benefit **Covered Loss** means:

1. For a foot or hand, actual severance through or above the ankle or wrist joint;
2. For thumb and index finger, complete severance through or above the metacarpophalangeal joint of both digits;
3. Total and permanent loss of sight;
4. Total and permanent loss of speech; or
5. Total and permanent loss of hearing.

Exposure Benefit..... $15,000

If you are exposed to weather because of an accident and this results in a covered loss, we will pay the applicable amount shown in the policy schedule subject to all policy terms.

If the conveyance in which you are riding disappears, is wrecked, or sinks, and you are not found within 365 days of the event, we will presume that you lost your life as a result of injury. If travel in such conveyance was covered under the terms of the policy, we will pay the applicable amount shown in the policy schedule, subject to all policy terms. We have the right to recover the benefit if we find that you survived the event.

Accident Excess Integrated Medical Expense Benefit.....Accident Medical Maximum Benefit: $25,000

We will pay our share of the usual and customary expenses for medically necessary **covered medical service(s)** incurred by you resulting from a covered accident while participating in a covered activity, up to the maximum benefit shown on the policy schedule. Coverage is provided in excess of the deductible shown in the accident medical expense schedule provided that:

1. the first treatment or service occurs within ninety (90) days of the covered injury; and
2. the medical expenses are incurred within fifty-two (52) weeks of the covered injury.

For this benefit only, the following definitions apply:

Covered Medical Service(s) means any of the following services:

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 or miscellaneous inpatient Hospital expenses: services and supplies including operating room, 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 emergency room or 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 (including ambulatory surgical facilities).
5. Diagnostic X-rays, laboratory procedures and tests.
6. Treatment for heat stroke and heat exhaustion.
7. 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.
8. Physician's surgical expenses that require singular or 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. The Physician's surgical procedure(s) must be the result of a Covered Injury.
9. Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a Physician's surgical procedure whether on an inpatient or outpatient basis. The Physician's surgical procedure(s) must be the result of a Covered Injury.
10. Assistant Physician expenses.
11. The services of a Registered Nurse (the nurse cannot be a member of the Insured's immediate family).
12. Physiotherapy expenses on an inpatient or outpatient basis. 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 and/or occupational therapy.
13. Radiological procedures including: cardiac imaging and nuclear medicine and molecular imaging related to a Covered Injury and prescribed by a Physician.
14. Diagnostic imaging expenses including Magnetic Resonance Imaging (MRI) and Computed Axial Tomography (CAT) Scan related to a Covered Injury and prescribed by a Physician.
15. Ambulance expenses for transportation from the emergency site to the Hospital.
16. Rehabilitative limb braces, wheelchairs and other medical equipment or appliances prescribed by a Physician and related to the Covered Injury. 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.

    We will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs.
17. Eyeglasses, contact lenses or hearing aids damaged or destroyed as a result of a Covered Injury and prescribed by a Physician.
18. Prescription drug expenses for Covered Injuries, prescribed by a Physician and administered on an outpatient basis.
19. Expenses for blood, blood transfusions and oxygen (including delivery of tanks and equipment and its administration).
20. Dental treatment for teeth, gums or structures directly supporting the teeth performed as a result of a Covered Injury.
21. Treatment resulting from complications of pregnancy due to a Covered Injury.

EXCESS INTEGRATED

The benefit amount for this benefit is payable in excess of any In Force Policy and its applicable deductible. In the event and only in the event of the reduction or exhaustion of the limit of insurance of the In Force Policy solely as the result of actual payment of benefits covered thereunder, the Policy shall pay excess of the reduced limit of insurance of the In Force Policy and its applicable deductible. The Policy shall only pay pursuant to the terms and conditions of the Policy and no other policy.

We will pay the Usual and Customary amount, reduced by the payment by any other insurance plan. The Policy will recognize payment by any other insurance plan as reducing or satisfying the deductible amount of the Policy. In no event will We pay more than the maximum amount stated in this rider.

If no In Force Policy exists, the Policy will pay benefits on a primary basis subject to the deductible and coinsurance amounts stated in the Schedule.

Heart Failure Benefit $15,000

If you suffer a Covered Injury resulting in a Covered Loss as a result of a Covered Accident, which is a result of a Heart Failure, We will pay an additional amount shown in the Schedule. The Heart Failure must occur within twenty-six (26) weeks of the Covered Accident. Heart Failure means death because the heart ceases to beat due to failure of the heart to maintain adequate circulation of blood provoked by participation in a Covered Activity.

To File a Claim

Contact Bob McCloskey Insurance for a claim form.

Bob McCloskey Insurance
P.O. Box 511
Matawan, NJ 07747
800-445-3126

Complete the form and send it to the within 90 days of the loss. Refer to Plan Number MCB 5465797.

Beneficiary Designation

Loss of Life of an Insured. Covered losses resulting from your death are paid to your named beneficiary at the time of death. If there is no beneficiary named or your named beneficiary predeceases or dies at the same time as you, we will pay the benefit to your estate: All other claims will be paid to you.

All Other Claims. Benefits are to be paid to you. You may direct in writing that all, or part of the Accident Excess Integrated Medical Expense Benefit if applicable, will be paid directly to the party who furnished the service. The direction may be changed by you at any time up to the filing of the Proof of Covered Loss.

Payment for a Foreign National Employee

If you are a is a citizen of a country or other jurisdiction other than the United States of America and who is not a resident of the United States of America and are entitled to benefits for a covered loss and we are unable to make payment directly to him or her because of legal restrictions in the country or jurisdiction where you are located, we will either: (1) pay the benefits to a bank account owned by you in the United States of America; or (2) if no such bank account is established or maintained, we will pay the benefits to the policyholder on your behalf. It will then be the responsibility of the policyholder to remit the benefit to you. Payment of the benefit to the policyholder will release us from any further liability to you. If the policyholder does not remit the payment to you, the policyholder will indemnify us and hold us harmless against any and all liability incurred by us including, but not limited to, interest, penalties, and attorneys' fees in connection with, arising or resulting from such failure to remit payment. The policyholder will not be considered the beneficiary under the policy if payment is made to the policyholder in accordance with this provision.

General Exclusions

A loss shall not be a covered loss if it is caused by, contributed to, or resulted 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; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; except for Accidental ingestion of contaminated foods.
5. participation in the commission or attempted commission of any felony, an assault, insurrection or riot.
6. being intoxicated while operating a motor vehicle.
    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 hospital records 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 is entitled to benefits under any Workers' Compensation Act, No Fault Auto 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.

General Limitations

Benefits are payable only for covered losses incurred as a result of participation in covered activities.

Limitation on Multiple Covered Losses: If you suffer more than one covered loss as a result of the same accident, we will pay only one benefit, the largest benefit.

Limitation on Multiple Covered Activities: If you suffer a covered loss while participating in more than one covered activity, we will pay only one benefit, the largest benefit.

Limitation of Multiple Benefits: If you can recover benefits under more than one of the Benefits stated in the Schedule, as a result of the same accident, we will pay only one benefit, the largest benefit.

Limitation on Mulitple Covered Poliices: If you can recover benefits under more than one accident policy written by Zurich American Insurance Company, we will pay under only one policy, the policy which offers you the largest benefit.

Additional Exclusions for the Accident Medical Expense Benefit

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 is entitled to benefits under Workers Compensation Benefits, Employer Liability Law, or any statutorily mandated coverage.
4. Personal comfort or convenience items, such as but not limited to Hospital telephone charges, television rental, guest meals, or internet charges.
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, contact lenses 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.
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, as prescribed by a Physician.
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 as a direct 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.

Important

This is a brief description of the coverage provided through the participant accident plan. If any conflict should arise between the contents of this handout and the master policy or if any point is not covered herein, the terms of the master policy shall govern in all cases.

Sanctions Exclusion Endorsement

Notwithstanding any other terms under the policy, we shall not provide coverage nor will we make any payments or provide any service or benefit to any insured, beneficiary, or third party who may have any rights under the policy to the extent that such coverage, payment, service, benefit, or any business or activity of the insured would violate any applicable trade or economic sanctions law or regulation.

Zurich

1299 Zurich Way, Schaumburg, Illinois 60196-1056
800-382-2150 www.zurichna.com