ARCH INSURANCE COMPANY
(A Missouri Corporation)

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MASSACHUSETTS BLANKET ACCIDENT POLICY

POLICYHOLDER	**APPALACHIAN MOUNTAIN CLUB**		
POLICY NUMBER	**11SPR0928401**	**POLICY EFFECTIVE DATE**	**MAY 25, 2019**
POLICYHOLDER ADDRESS	**10 CITY SQUARE CHARLESTOWN, MA 02129**	**POLICY ANNIVERSARY DATE**	**MAY 25**
POLICY TERM	**MAY 25, 2019 – MAY 24, 2020**		

This Policy takes effect at 12:01 AM on the Policy Effective Date shown above at the address of the Policyholder. The Policy terminates at 11:59 PM on the last day of the Policy Term unless the Policyholder and the Company agree to continue coverage under this Policy for an additional Policy Term. If coverage is continued for an additional Policy Term and the required premiums are paid on or before the premium date, the Company will issue a Policy to identify the new Policy Term. It continues in effect in accordance with the provisions set forth in this Policy.

The insurance provided by this Policy is limited to the amounts indicated in the Schedule, for the Covered Activities to be insured against. It is only provided with respect to the Covered Person in the eligible class as shown.

The Company agrees to provide insurance to the Policyholder in exchange for the payment of the required premium. The Policy contains the terms under which the Company agrees to insure Covered Persons and pay benefits.

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

IN WITNESS WHEREOF, Arch Insurance Company has caused this policy to be executed and attested.

Patrick K. Nails
Secretary

John Mentz
President

THIS IS A BLANKET ACCIDENT INSURANCE POLICY.
IT PAYS FOR SPECIFIC LOSSES FROM ACCIDENTS ONLY.
THE POLICY DOES NOT PAY BENEFITS FOR LOSSES DUE TO SICKNESS.
PLEASE READ THE POLICY CAREFULLY.

THIS POLICY CONTAINS A DEDUCTIBLE PROVISION
THIS POLICY CONTAINS AN EXCESS PROVISION

TABLE OF CONTENTS

Section **Page**

SECTION I - SCHEDULE OF BENEFITS

POLICYHOLDER	**Appalachian Mountain Club**
POLICY NUMBER	**11SPR0928401**
POLICY EFFECTIVE DATE	**MAY 25, 2019**
POLICY PERIOD	**MAY 25, 2019 – MAY 24, 2020**
PREMIUM DUE DATE	**Annual in Advance**
CLAIMS ADMINISTRATOR	Arch Insurance Solutions Executive Plaza IV, 11350 McCormick Road, Suite 102 Hunt Valley, MD 21031

CLASSES OF ELIGIBLE PERSONS
A person may be insured only under one Class of Eligible Persons even though he or she may be eligible under more than one class.

Class 1	All registered participants of the Appalachian Mountain Club while participating in U.S. Supervised and Sponsored Activities of the Appalachian Mountain Club for whom premium has been paid.
Class 2	All registered participants of the Appalachian Mountain while participating in internationally Supervised and Sponsored Activities of the Appalachian Mountain Club for whom premium has been paid.

PREMIUMS
$1.15 per participant per day
Estimated annual premium: $9,367
True-up will be performed at 6 months and at the end of the policy term

AGGREGATE LIMIT OF LIABILITY

Benefit Maximum	$300,000
Applies During	per Covered Accident
Applies To	Accidental Death & Dismemberments benefits only

COVERED ACTIVITIES
The following are the Covered Activities for which insurance applies:

Class	**Covered Activity**
Class 1 and 2	Supervised and Sponsored Activities

Covered Activities: While participating in the Policyholder's scheduled, sponsored and supervised activities, including travel to and from such activities in the Policyholder's furnished transportation.

Subject to all the terms and conditions of the Policy, benefits described in the Policy are payable when a Covered Person suffers a Loss or Injury as a result of a Covered Accident during one of the Covered Activities listed above. Benefits are payable only once for any Covered Accident even if it is covered by more than one Covered Activity. The Benefit amount will be the largest Benefit amount applicable under all such Covered Activities.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Class 1 and 2 Principal Sum: $5,000

Time Period for Loss: 365 days

ACCIDENT MEDICAL AND DENTAL EXPENSE BENEFIT

Total Benefit Maximum for all Accident Medical And Dental Expense Benefits	$5,000
First Covered Expenses must be incurred within	30 days after the Covered Accident
Benefit Period	1 year from the date of the Covered Accident
Deductible	$0
Scope of Coverage	
Class 1	Full Excess
Class 2	Primary

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

Covered Expense	**Benefit Amount – Usual and Customary**
Daily Hospital Room and Board	100% of the semi-private room rate
Daily Intensive Care Unit	100% of the daily intensive care unit room rate
Ancillary Hospital Expenses	100%
Physician Office Visit Includes physician assistants, certified nurse practitioners, certified psychiatric-mental health clinical nurse specialists, certified nurse-midwives, or licensed chiropractor.	100%
Physician Surgical Expenses Includes physician assistants, certified nurse practitioners, certified psychiatric-mental health clinical nurse specialists, certified nurse-midwives, or licensed chiropractor.	100%
Emergency Room and Supplies	100%
Ambulance	100%
Outpatient Surgery Visit	100%
Outpatient Surgical Room and Supplies	100%
Outpatient Laboratory Tests and X-Rays	100%
Physical Medicine	100%
Anesthesiologist Expenses	100%

Dental Expenses	100%
Prescription Drugs	100%
Medical Equipment Rental	100%
Medical Services and Supplies	100%

ADDITIONAL ACCIDENT BENEFITS

Any benefits payable under these Additional Accident Benefits shown below are paid in addition to any other Accidental Death and Dismemberment benefits payable, unless specifically noted otherwise.

Emergency Medical Evacuation Benefit

Maximum Benefit per Covered Accident	$200,000

Repatriation Benefit

Maximum Benefit	$200,000

SECTION II – DESCRIPTION OF COVERED ACTIVITIES

We will only pay benefits if the Insured is engaged in one of the Covered Activities described below, as listed in the Schedule of Benefits, when the Covered Accident occurs. Unless otherwise specified, We pay benefits only once for any one Covered Accident, even if covered by more than one Covered Activity. We shall pay the single largest benefit amount applicable under all such Covered Activities.

Supervised and Sponsored Activities

The Covered Accident must take place:

1. on the premises of the Policyholder during normal hours of operation or during scheduled functions; or
2. on the premises of the Policyholder during other periods if attending or participating in a Covered Activity; or
3. away from the premises of the Policyholder while attending or participating in a Covered Activity at its scheduled site.

The Covered Activity includes travel without delay, deviation or interruption between home and the site of the Covered Activity.

Benefits are paid as described in this Policy if the Covered Accident occurs while the Covered Person is in a vehicle designated or furnished by the Policyholder, operated by a properly licensed adult driver who is under the direct supervision of the Policyholder.

Travel time includes the time:

1. to or from home and the premises of the Covered Activity;
2. before the appointed time; and
3. after the Covered Activity is completed.

SECTION III - DEFINITIONS

For the purposes of this Policy, certain words with specific meanings are capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found in the Schedule of Benefits or in this Definitions Section.

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

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

COMBINED MAXIMUM LIMIT means the maximum amount for which We are liable for a Covered Person due to any one Accident.

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

COVERED ACTIVITY means any activity that the Policyholder requires the Covered Person to attend, or that is under its supervision and control listed in the Schedule of Benefits and insured under the Policy.

COVERED EXPENSES means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies covered by this Policy. Coverage under the Policyholder's Policy must remain continuously in force from the date of the Covered Accident until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained.

COVERED LOSS or COVERED LOSSES means an accidental death, dismemberment or other Injury covered under this Policy.

COVERED PERSON means an eligible person who is within the covered class(es) listed in the Policy and for whom the required premium is paid when due.

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

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

We will not deny a claim for services rendered in a hospital having one or more of the following accreditations solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability:
1) the Joint commission of Accreditation of Hospitals; or
2) the American Osteopathic Association; or
3) the Commission on the Accreditation of Rehabilitative Facilities.

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

INSURED means an eligible person who is within the covered class(es) listed in the Policy and for whom the required premium is paid when due.

MEDICALLY NECESSARY means a treatment, service or supply that is:
1) required to treat an Injury;
2) prescribed or ordered by a Physician or furnished by a Hospital;
3) performed in the least costly setting required by your condition;
4) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

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

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

PHYSICIAN means a person who is a qualified doctor of medicine or dental practitioner As such, he or she must be acting within the scope of his or her license under the laws in the state in which he or she practices and providing only those medical services which are within the scope of his or her license or certificate. It does not include a Covered Person, an Insured's spouse, son, daughter, father, mother, brother or sister or other relative.

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

WE, OUR, US means the Insurance Company underwriting this insurance or its authorized agent.

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

SECTION IV - ELIGIBILITY FOR INSURANCE

If the Covered Person is in one of the classes of Eligible Persons shown on the Policy Schedule of Benefits, he or she is eligible to be covered on the Policy Effective Date. The Company retains the right to: investigate eligibility status; and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

SECTION V - EFFECTIVE DATE OF INSURANCE

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

Covered Person's Effective Date

A Covered Person's coverage under this Policy begins on the later of:
1) the Policy Effective Date; or
2) the date such person becomes eligible, subject to any required waiting period; as described in the Schedule of Benefits.

SECTION VI - TERMINATION DATE OF INSURANCE

Policy Termination Date
Termination takes effect at 11:59 P.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination.

This Policy terminates automatically on the earlier of:
1) The Policy Termination Date shown in this Policy; or
2) The premium due date if premiums are not paid when due; subject to the grace period provided in the section of this Policy entitled Premium.

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

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

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

1) The date this Policy terminates;
2) The date the Covered Person requests, in writing, that his or her coverage be terminated;
3) The date the Covered Person enters full-time active duty in the armed forces of any country or international authority;
4) The date the Covered Person ceases to be eligible as described in this Policy provided all required premiums are paid; or
5) The last day of the period for which premiums have been paid; or
6) The date the Covered Person is no longer Actively at Work, provided all required premiums are paid, unless otherwise provided below.

Any continuation of coverage must be based on rules that preclude individual selection and is subject to this Policy remaining in force.

SECTION VII - DESCRIPTION OF BENEFITS

The following provisions explain the benefits available under the Policy. All benefits payable are shown in the Schedule of Benefits.

AGGREGATE LIMIT OF LIABILITY

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

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

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If Injury to the Covered Person results in any of the Covered Losses shown below, within the Time Period for Loss as shown in Schedule of Benefits, 365 days from the date of the Covered Accident that caused the Injury, the Company will pay the percentage of the Principal Sum shown below for that loss. The Principal Sum is shown in the Schedule of Benefits. If multiple losses occur, only one benefit, the largest, will be paid for all losses due to the same Covered Accident.

Loss of:	**Benefit:** (Percentage of Principal Sum)
Life	100%
Two or More Members	100%
Quadriplegia	100%
Hemiplegia	75%
Paraplegia	75%
One Member	50%
Uniplegia	25%
Thumb and Index Finger of the Same Hand	25%

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

"Paralysis" means total loss of use.

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

"Paraplegia" means total Paralysis of both lower limbs.

"Quadriplegia" means total Paralysis of both upper and lower limbs.

"Uniplegia" means total Paralysis of one lower limb or one upper limb.

ACCIDENT MEDICAL AND DENTAL EXPENSE BENEFIT

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

Accident Medical Expense Benefits are only payable:

1) for Usual and Customary Charges incurred after the Deductible has been met;
2) for those Medically Necessary Covered Expenses incurred by or on behalf of the Covered Person;
3) for charges incurred within 365 days after the date of the Covered Accident.

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

Covered Medical Expenses, from a Covered Accident, include:

1) Hospital room and board expenses; the daily room rate when a Covered Person is Hospital confined and general nursing care is provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
2) Daily Intensive Care Unit or Cardiac Care Unit Expenses; the daily room rate when a Covered Person is Hospital confined in a bed in the Intensive Care Unit or Cardiac Care Unit and nursing services other than private duty nursing services.
3) Ancillary Hospital expenses; services and supplies including operating room; laboratory tests; anesthesia and medicines (excluding take home drugs) when Hospital confined.
4) Physician Office Visit; non-surgical treatment or examination expenses (excluding medicines) including the Physician's initial visit; each necessary follow-up visit; and consultation visits when referred by the attending Physician.
5) Physician surgical expenses. If an injury requires multiple surgical procedures through the same incision, we will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, we will pay for the most expensive procedure and 50% of Covered Expenses for the additional surgeries.
6) Emergency Room and Supplies expense incurred within 72 hours of a Covered Accident and including the attending Physician's charges; x-rays; laboratory procedures; use of the emergency room and supplies.
7) Ambulance expenses for transportation from the emergency site to the Hospital.
8) Outpatient surgery visit; office visits connected with such treatment when prescribed by a Physician.
9) Outpatient surgical room and supply expenses for use of the surgical facility. Second surgical opinion expense. Assistant surgeon expense when medically Necessary.
10) Outpatient diagnostic x-rays; laboratory procedures; and test expenses. Does not include dental x-rays. Diagnostic imaging expenses including: magnetic resonance imaging (MRI) and CAT scans.
11) Physical Medicine (Physiotherapy) expenses on an inpatient or outpatient basis limited to one visit per day; expenses include treatment and office visits connected with such treatment when prescribed by a Physician, including: diathermy; ultrasonic; whirlpool; heat treatments; adjustments; manipulation; massage or any form of physical therapy.
12) Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
13) Dental expenses including dental x-rays for the repair or treatment of each injured tooth that is whole sound and a natural tooth at the time of the Covered Accident. Dental expenses related to the installation of crowns; caps; bridges and dentures; oral surgery and endodontics as a result of a Covered Accident. Repair or replacement of caps and crowns that existed prior to the Covered Accident.
14) Prescription drug expenses prescribed by a Physician and administered on an outpatient basis.
15) Medical equipment rental expenses for a wheelchair or other medical equipment that has therapeutic value for the Covered Person. We will not cover computers; motor vehicles or modifications to a motor vehicle; ramps and installation costs; eyeglasses and hearing aids.
16) Medical services and supplies for blood and blood transfusions; oxygen and its administration.

ADDITIONAL ACCIDENT BENEFITS

Emergency Medical Evacuation Benefit

We will pay Covered Expenses, up to expenses incurred to the Maximum Benefit shown in the Schedule of Benefits, subject to the following conditions for emergency medical evacuation, if:

1. The Covered Person suffers a Covered Loss resulting directly; and independently of all other causes; from a Covered Accident that occurs while traveling from his or her principal residence to another city or foreign country, with at least 100 miles distance.
2. The Covered Person's attending Physician certifies an emergency need to send the Covered Person, under medical supervision, to the nearest medical facility.

Eligible expenses include:

1. charges for ambulance services required while transporting the Covered Person to the nearest appropriate treatment facility; or
2. charges for medical services required to send the Covered Person to the nearest appropriate treatment facility; or
3. reimbursement of economy class transportation charges for return of the Covered Person from the treatment facility to home, paid for by the Covered Person within one year from the date he or she was first schedule to return form the trip. Any refunds paid or payable from the unused transportation tickets will reduce benefits; or
4. charges for necessary travel expenses of an escort, that are limited to food; hotel room; and economy class transportation charges; and
5. only the charges incurred that are Medically Necessary and do not exceed the Usual and Customary Charges for similar treatment; services; or supplies in the locality where the expense is incurred; and do not include charges that would not have been made if there were no insurance.

Benefits will not be payable unless: We authorize in writing, or by an authorized electronic means, all expenses in advance, and services are rendered by Our assistance provider. The Covered Person must, at his or her own expense, furnish: travel invoices; medical reports; or records, or other documents We require to determine if benefits are payable. Benefits will be paid to the party who actually paid for the expenses upon Our receipt of satisfactory proof that the expense was paid.

If the Covered Person pays eligible expenses for a Covered Loss for which We believe a third party is liable, We will pay the benefits for emergency medical evacuation. However, if the Covered Person recovers payment from the third party, he or she must refund to Us the lesser of:

1. the amount We paid for the eligible expenses; and
2. an amount equal to the sum received from the third party for such expenses.

Benefits will not be paid for any of the following:

1. expenses that exceed the Maximum Benefit;
2. services not pre-approved by Us, or for services performed by a vendor not authorized by Us; or
3. expenses paid or payable by any Workers' Compensation, occupational disease or similar law that would pay emergency medical evacuation expenses in the absence of this benefit.

Repatriation Benefit

We will pay Eligible Expenses, as shown in the Schedule of Benefits, incurred for the return of the Covered Person's remains to his or her place of residence in his or her home country and state if the Covered Person's death results directly; and independently of all other causes; from a Covered Accident outside of his or her home state or more than 100 miles from the Covered Person's place of residence.

"Eligible Expenses" means costs, pre-approved by Us and incurred for embalming; cremation; coffin or urn; transportation of the body or remains; necessary travel expenses of an escort. Necessary travel expenses are limited to food; hotel room; and economy class transportation charges.

SECTION VIII – SCOPE OF COVERAGE

Accident Medical and Dental Expense Benefits will be paid according to the following basis.

Primary Benefits

If a Covered Person incurs Covered Expenses, We will pay the applicable benefit, subject to any applicable Deductible and Benefit Period as shown on the Schedule of Benefits. Such benefits will be paid on a primary basis, regardless of any other coverage the Covered Person may have. The first expense must be incurred within the Loss Period stated on the Schedule of Benefits. The Total Benefit Maximum payable and sub-limits under the Policy are shown on the Schedule of Benefits.

Full Excess Benefits

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

"Health Care Plan" means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:

1. group or blanket insurance, whether on an insured or self-funded basis;
2. hospital or medical service organizations on a group basis;
3. Health Maintenance Organizations on a group basis;
4. group labor management plans;
5. employee benefit organization plan;
6. professional association plans on a group basis;
7. any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended; or
8. automobile no-fault coverage (unless prohibited by law).

SECTION IX - PREMIUM

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

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

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

Changes in Premium Rate

The Company may change the premium rates from time to time with at least 31 days advanced written or authorized electronic notice. No change in rates will be made until 12 months after the Policy Effective Date. However, the Company reserves the right to change rates at any time if any of the following events occur:

1) A change in the terms of the Policy.
2) A subsidiary; division; affiliated organization; or eligible class is added or deleted to the Policy.
3) A change in any federal; or state law; or regulation affecting this Policy and our benefit obligation.

4) A change in the factors bearing on the risk assumed.
5) A misrepresentation in the information relied on in establishing the rate for this Policy.
6) The number of Covered Persons or persons eligible for coverage or Estimated Volume of Insurance increases or decreases by more than 10% since the later of the Policy Effective Date or the date of the last renewal of this Policy.
7) The Policyholder fails to provide sufficient information, as required by Us, to confirm adequacy and accuracy of premiums and rates being paid.

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

Grace Period
After the payment of the first premium, this Policy will have a 31 day grace period. This means that if premium is not paid on or before the date it is due, it may be paid during the 31 day grace period. During this time, this Policy will stay in force provided the Policyholder pays all the premiums due by the last day of the grace period; unless the Policyholder gives Us written notice of the discontinuance of the coverage in advance of the date of discontinuance and in accordance with the terms of the Policy. This Policy will terminate on the last day of the period for which all premiums have been paid if the Policyholder fails to pay all premiums due by the last day of the grace period.

Premium Audit
We will have the right to audit books and records of the Policyholder at its place of business and during its regularly scheduled business hours, in order to determine the accuracy of premiums paid.

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

SECTION X - CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice of claim; death; or injury must be given to the Company or its designated representative within 20 days after a Covered Loss begins or as soon as reasonably possible. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably practicable. Notice can be given to the Company at our claims office noted on Section I - Schedule of Benefits. Notice should include the Covered Person's name, address, Policyholder name and Policy Number.

CLAIM FORMS: When the Company receives a notice of claim, the Company will send forms for filing proof of loss. If claim forms are not sent within 15 days the claimant will satisfy the requirements of written proof of loss by sending the written proof as shown below. Proof of loss must describe the occurrence, extent and nature of the loss.

PROOF OF LOSS: Written proof of loss must be given to the Company within 90 days after the date of loss. If the proof of loss is not submitted within 90 day, it should be sent as soon as reasonably possible; otherwise the claim may be reduced or invalidated. In no event, except in the absence of legal capacity, should proof of loss be sent later than one year from the time proof is otherwise required.

BENEFICIARY: The Covered Person may designate a beneficiary. The Covered Person has the right to change the beneficiary from time to time by written notice. If it is necessary to designate a beneficiary for a minor, the parent or guardian may exercise that right. The change will be effective when We receive it. When received, the effective date is the date the notice was signed. We are not liable for any payments made before the change was received. We cannot attest to the validly of a change.

PAYMENT OF CLAIMS: The Company, or its designated representative, will pay a claim after receipt of acceptable proof of loss. Benefits for loss of life are payable to Covered Person's beneficiary. The designation shall be as follows:

1) Beneficiaries designated in writing by the Covered Person for this Policy on file with the Policyholder, if any, otherwise;
2) Beneficiaries as designated in writing for any group life insurance plan or its renewals in force for the Policyholder, if any, otherwise;

If a beneficiary is not otherwise designated by the Covered Person, benefits for loss of life will be paid to the first of the following surviving preference beneficiaries:

1) the Covered Person's Spouse or Domestic Partner;
2) the Covered Person's child or children jointly;
3) a Covered Person's parents jointly if both are living or the surviving parent if only one survives;
4) a Covered Person's brothers and sisters jointly; or
5) the Covered Person's estate.

All other claims will be paid to the Covered Person. In the event the Covered Person is a minor, incompetent or otherwise unable to give a valid release for the claim, the Company may make arrangement to pay claims to the Covered Person's legal guardian, committee or other qualified representative. All or a portion of all other benefits provided by this Policy may, at the option of the Company, be paid directly to the provider of the service(s). All benefits not paid to the provider will be paid to the Covered Person.

Any payment made in good faith will discharge the Company's liability to the extent of the claim.

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

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

RIGHT OF RECOVERY: A Covered Person may incur charges due to an Injury for which benefits are paid by this Policy. The injury may be caused by the act or omission of another person. If so, the Covered Person may have a claim against that other person for payment of expense-incurred charges. If Recovery under the claim is made, the Covered Person must repay Us the Recovery made from: 1) another person; 2) insurance companies; or 3) other organizations.

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

Net Recovery means the Covered Person's Recovery less attorney's fees and court costs incurred in making the Recovery. Refund means repayment to Us for benefits paid.

TIME OF PAYMENT OF CLAIMS: Benefits for loss covered by this Policy, other than benefits that require periodic payment, will be paid not more than forty-five (45) days after the Company receives proper written proof of such loss. Benefits for loss covered by this Policy that require periodic payment shall be paid on a timely basis provided that the Company receives proper written proof of such loss. If payment is not made within forty-five days from said receipt of notice, the Company will notify the claimant in writing specifying the reasons for the nonpayment or whatever further documentation is necessary for payment of said claim within the terms of the Policy. If the Company fails to comply with the provisions of this paragraph, the Company will pay, in addition to any benefits which inure to such claimant or provider, interest on such benefits, which shall accrue beginning forty-five days after the insurer's receipt of notice of claim at the rate of one and one-half percent per month, not to exceed eighteen percent per year. The provisions of this paragraph relating to interest payments do not a claim which the Company is investigating because of suspected fraud.

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

SUBROGATION: To the extent the Company pays for a loss suffered by an Insured Person, the Company will take over the rights and remedies the Insured Person had relating to the loss. This is known as subrogation. The Insured Person must help the Company to preserve its rights against those responsible for the loss. This may involve signing any papers and taking any other steps the Company may reasonably require. If the Company takes over an Insured Person's rights, the Insured Person must sign an appropriate subrogation form supplied by the Company. The Company has the right to offset future benefits payable to the Covered Person under this Policy against any such Recovery.

SECTION XI -GENERAL POLICY PROVISIONS

ASSIGNMENT: This Policy is not assignable, whether by operation of law or otherwise. Benefits may be assigned. No assignment of interest in loss of life benefits shall be binding on the Company until the original or duplicate thereof is received by the Company. The Company assumes no responsibility for the validity of such assignment.

CERTIFICATES OF INSURANCE: Where it is required by law, or upon request of the Policyholder, the Company will make available to all Covered Persons certificates outlining the benefits; conditions; exclusions; and limitations of this Policy.

CLERICAL ERROR: Clerical error in keeping any records pertaining to the coverage, whether by the Policyholder or by the Company, will not invalidate coverage otherwise validly in force; nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to the Company and is rectified promptly upon discovery. No error will continue the insurance of a Covered Person beyond the date it should end under the Policy terms. After an error is found, the Company will take appropriate action, which may include adjusting, collecting or refunding premium.

CONFORMITY WITH STATE STATUTES: On the effective date of this Policy, any provision of this Policy in conflict with the laws of the state where it is issued is amended to conform to the minimum requirements of such laws.

ENTIRE CONTRACT/CHANGES: This Policy, including any endorsements; amendments; and attached papers; the signed application of the Policyholder; and any individual applications of Covered Persons is the entire contract between the Policyholder and the Company. A copy of the application, if any, of the Policyholder shall be attached to the Policy when issued. All statements made by the Policyholder or by a Covered Person are deemed representations and not warranties. No such statement will cause the Company to void the insurance under this Policy or be used as a defense of a claim, unless it is contained in a written application.

Valid changes to this Policy may be made at any time by an endorsement or amendment signed by Us, provided that any such amendment which reduces or eliminates coverage was either requested in writing by the Policyholder or signed by the Policyholder. The Company may also, upon 31 days written notice to the Policyholder, change or modify the provisions of this Policy to comply with any applicable requirements of the Internal Revenue Service and any state or other federal law or regulation. No agent may change this Policy or waive any of its provisions.

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

INCONTESTABILITY: Except for nonpayment of premiums, We will not contest the validity of a Covered Person's coverage after it has been in force for two years from its date of issue. No statement made by a Covered Person relating to his insurability shall be used to contest the validity of his insurance after the insurance has been in force for two years during his lifetime, exclusive of any period of disability; nor unless it is contained in a written application signed by him.

LEGAL ACTIONS: No legal action may be brought to recover on this Policy until there has been full compliance with all the terms of this Policy. All Policy terms will be interpreted under the laws of the state in which this Policy was issued. No legal action may be brought to recover on this Policy before 60 days following the date written Proof of Loss was given to Us. No legal action may be brought against the Company more than two (2) years after the time required for written Proof of Loss.

MISREPRESENTATION AND FRAUD: This entire Policy will be void, whether before or after a loss, if the Company determines that the Policyholder; Covered Person; or its agent has concealed or misrepresented any material fact or circumstance concerning this Policy, including any claim or any case of fraud by the Policyholder; Covered Person; Third Party Administrator; or other agent relating to this Policy.

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

PAYMENT OF PREMIUM: The Company provides insurance in return for the payment of premiums. The Premiums are to be paid to the Company by the Policyholder. The first Premium is due on the Policy Effective Date. After that premiums will be due monthly unless shown otherwise in the Schedule of Benefits. If any premium is not paid when due, the Policy will be cancelled as of the Premium Due Date; except as provided in the Policy Grace Period provision.

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

WORKERS' COMPENSATION: This Policy is not a Workers' Compensation policy. It does not provide Workers' Compensation benefits; and does not satisfy any requirements for coverage by any Workers' Compensation Act or similar law.

SECTION XII – EXCLUSIONS

This Policy does not cover any loss or Injury resulting or caused, in whole or part, from:

1. Suicide or attempted suicide; self-destruction or attempted self-destruction while sane or insane.
2. Intentionally self-inflicted injury.
3. Service, training, or active duty in the armed forces; National Guard; military; naval; or air service; or organized reserve corps of any country or international organization.
4. Sickness; disease; bodily or mental infirmity; or any bacterial or viral infection; or medical or surgical treatment thereof, except for any bacterial infection that results from: accidental ingestion of contaminated food substances; or pyogenic infections that result from an accidental external cut or wound.
5. Alcoholism; drug addiction; or the use of any drug or narcotic except as prescribed by a Physician.
6. Voluntarily taking any drug or narcotic unless the drug or narcotic is prescribed by a Physician.
7. Intoxication or being under the influence of any drug or narcotic. Intoxication is defined by the laws of the jurisdiction where such Accident occurs.
8. Violation of or attempt to violate any duly-enacted law or regulation; or commission or attempt to commit an assault; felony; or other illegal activity.
9. Actively participating in acts of terrorism, civil commotion or riots of any kind.
10. Travel or flight in or on any aircraft including boarding or alighting from:
    a. while riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
    b. while being used for any test or experimental purpose; or
    c. while piloting; operating; learning to operate; or serving as a member of the crew thereof; or
    d. while traveling in any such aircraft or device which is owned; chartered; controlled; or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Covered Person or any member of his household; or

e. being flown by the Covered Person or which the Covered Person is a member of the crew; or being used for: i) crop dusting; spraying or seeding; giving and receiving flying instructions; fire fighting; sky writing; sky diving or hang gliding; pipeline or power line inspection; bungee-cord jumping; parasailing; aerial photography or exploration; racing; endurance tests; stunts or acrobatic flying; or ii) any operation that requires a special permit from the FAA, even if it is granted. (This does not apply if the permit is required solely because of the territory flown over or landed on.); designed for flight above or beyond the earth's atmosphere;
f. which is an ultra light; or glider;
g. being used for the purpose of skydiving; or parachuting;
h. being used by any military authority; except an aircraft used by the Air Mobility Command or its foreign equivalent.

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

1. Treatment by persons employed or retained by a Policyholder; or by any Immediate Family; or member of the Covered Person's household.
2. Treatment of sickness; disease; or infections except pyogenic infections or viral or bacterial infections that result from the accidental ingestion of contaminated food substances.
3. Treatment of hernia; Osgood-Schlatter's Disease; osteochondritis; appendicitis; osteomyelitis; cardiac disease or conditions; pathological fractures; congenital weakness; hernia; detached retina unless caused by an Injury; or mental disorder; or psychological or psychiatric care or treatment (except as provided in the Policy); whether or not caused by a Covered Accident.
4. Pregnancy; childbirth; miscarriage; abortion; or any complications of any of these conditions.
5. Mental and Nervous Disorders (except as provided in the Policy).
6. Damage to or loss of dentures or bridges; or damage to existing orthodontic equipment ;except as specifically covered by the Policy.
7. Expense incurred for treatment of temporomandibular; or craniomandibular joint dysfunction; and associated myofacial pain (except as provided by the Policy).
8. Injury or loss contributed to by the use of drugs unless administered by a Doctor.
9. Covered medical expenses for which the. Covered Person would not be responsible for in the absence of this Policy.
10. Expenses payable by any automobile insurance policy without regard to fault. (This exclusion does not apply in any state where prohibited).
11. Replacement of artificial limbs; eyes; and larynx.
12. Cosmetic surgery; except for reconstructive surgery needed as the result of an Injury.

PRIVACY POLICY AND PRACTICES OF
ARCH INSURANCE COMPANY (ARCH)

Insurance companies must collect a certain amount of nonpublic personal information to serve customers and administer business. ARCH values your trust and is committed to the responsible management, use and protection of your nonpublic personal information. This notice describes our policy regarding the collection and disclosure of nonpublic personal information.

What is nonpublic personal information?

Nonpublic personal information, as used in this notice, means information that identifies an individual personally and is not otherwise available to the public. It includes information such as credit history, income, financial benefits, policy or claim information. It also includes personal health information such as individual medical records or information about an illness, disability, or injury.

Why does ARCH collect nonpublic personal information?

ARCH collects nonpublic personal information to support our normal business operations. We may obtain nonpublic personal information directly from you or from other parties, such as a consumer reporting agency. Personal information such as a name, address, income, payment history or credit history is gathered from sources such as applications, transactions and consumer reports.

With whom might ARCH share your nonpublic personal information?

We only disclose nonpublic personal information about you as permitted or as required by law. ARCH's employees have access to nonpublic personal information in the course of doing their jobs which includes underwriting policies, paying claims, developing new products or advising customers of our products and services. ARCH may share nonpublic personal financial information with our affiliates, such as insurance companies, agents, brokerage firms and administrators.

ARCH may also share information with unaffiliated third parties, including agents, brokerage firms, insurance companies, administrators and other service providers. We may also disclose nonpublic personal information as required by law. We may disclose personal health information with proper written authorization or as otherwise permitted or required by law.

What does ARCH do to make sure that nonpublic personal information is secure and confidential?

ARCH uses manual and electronic security procedures to maintain the confidentiality of personal information in our possession and guard against unauthorized access. Some techniques we employ to protect information include locked files, user authentication, firewall technology, and the use of detection software.

ARCH is responsible for identifying information that must be protected, providing an adequate level of protection for that data and granting access to protected data only to individuals who must use it in the performance of their job-related duties.

Does ARCH maintain confidentiality of nonpublic personal information after a policy expires?

ARCH will continue to follow this policy regarding nonpublic personal information even when you are no longer our customer.

We reserve the right to change our privacy policy. You will receive a notice of any such change.