

# Berkley Life and Health Insurance Company

Urbandale, Iowa

Administrative Office: 2445 Kuser Road, Suite 201, Hamilton Square, NJ 08690

**A Berkley Company**

**866.723.4452**

## Blanket Accident Policy

**Policyholder:** Envision Performing Arts, Inc.  
10580 North McCarran Boulevard  
Reno, NV 89503

**Policy Number:** PAI L00225053-001

**Effective Date:** 12/1/2011

**State of Issue:** Nevada

This Policy is a legal contract between the Policyholder and [Berkley Life and Health Insurance Company](#) (herein referenced as "the Company"). The Company agrees to provide insurance to the Policyholder, in exchange for the payment of the required premium. Coverage is subject to the terms and conditions described in this Policy.

This Policy and the coverage provided by it become effective at 12:01 A.M. at the address of the Policyholder on the Policy Effective Date shown above. It continues in effect in accordance with the provisions set forth in this Policy.

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

Signed for the Company:



President



Secretary

**THIS IS A BLANKET ACCIDENT INSURANCE POLICY.  
THE POLICY DOES NOT PAY BENEFITS FOR LOSSES CAUSED BY SICKNESS.  
THIS IS A LIMITED POLICY.  
PLEASE READ THE POLICY CAREFULLY.**

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## DEFINITIONS

The male pronoun includes the female whenever used.

For the purposes of this Policy the capitalized terms used herein are defined as follows:

**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.

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

**COVERED LOSS or COVERED LOSSES** means an accidental death, dismemberment or other Injury covered under this Policy and indicated on the Schedule of Covered Losses.

**COVERED PERSON** means an eligible person who is within the covered class(es) listed in the Policy, who is a U.S citizen residing in the United States, or if not a U.S. citizen, resides permanently in the United States, 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 Accident, before Accident Medical Expense Benefits and/or other Additional Benefits paid on an expense incurred basis are payable under this Policy. Only one Deductible will apply to the Covered Person and his or her Dependents if Injured in the same Covered Accident.

**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;
- 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 place for drug addicts, alcoholics or the aged.

We will not deny a claim for services 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, and the Hospital is accredited by any one of the following:

- 1) the Joint Commission of Accreditation of Hospitals; or
- 2) the American Osteopathic Association; or
- 3) the Commission on the Accreditation of Rehabilitative Facilities.

**IMMEDIATE FAMILY** means the Covered Person's parent, grandparent, spouse, Child(ren) (includes legally adopted or step Child(ren), brother, sister, step-Child(ren), grandchild(ren), or in-laws.

**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.

**MEDICAL EMERGENCY** means a condition caused by an Injury that manifests itself by symptoms of sufficient severity that a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

**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 the 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 practitioner of the healing arts, including a chiropractor and a dental practitioner. As such, He or She must be acting within the scope of his/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/her license or certificate. It does not include a Covered Person, a Covered Person'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 [Berkley Life and Health Insurance Company](#) underwriting this insurance.

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

## **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. We retain 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.

## **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.

## TERMINATION DATE OF INSURANCE

### Policy Termination Date

Termination takes effect at 12:01 A.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 any grace period.

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.

This Policy may be terminated by the Policyholder or the Company as of any premium due date or Policy Anniversary Date by giving written notice to the other at least 31 days prior to such date.

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

If premiums have been paid beyond the termination date, the Company will refund the excess; or if premiums have been paid short of the termination date, the Policyholder will owe the Company the difference.

### 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 enters full-time active duty in the armed forces of any country or international authority;
- 3) The date the Covered Person ceases to be eligible as described in the Policy provided all required premiums are paid; or
- 4) The last day of the period for which premiums have been paid.

## PREMIUMS

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 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 to 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. An

increase in rates will not be made more than once in a 12 month period. 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.

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. 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.

## **HAZARDS INSURED AGAINST**

We will pay benefits described in this Policy when a Covered Person suffers a Covered Loss or Injury as a result of a Covered Accident during one of the Covered Activities listed in the Schedule of Benefits. Unless otherwise specified, We pay benefits only once for any one Covered Accident, even if it is covered by more than one Hazard.

### **SPORTS COVERAGE**

We will pay the benefits described in the Policy for an Accident which occurs while a Covered Person is:

- (1) taking part in:
  - (a) a regularly scheduled athletic game or competition; or
  - (b) a practice session for an athletic team or club; or
- (2) traveling to or from such a game, competition or practice session provided he is:
  - (a) traveling with the athletic team or club; and
  - (b) under the direct and immediate supervision of:
    - (i) the athletic team or club; or
    - (ii) an adult authorized by the athletic team or club; or
- (3) traveling directly, without interruption:
  - (a) between his home and a scheduled game, competition or practice session;
  - (b) in a vehicle which is operated by a properly licensed driver.

Travel time includes the time:

- (1) to or from home, a scheduled game, competition or practice session;
- (2) before required attendance time;
- (3) after the Covered Person is dismissed; and
- (4) after the Covered Person completes extra duties assigned by the Policyholder.

Conditions which result over a period of time (such as blisters, tennis elbow, heat exhaustion, hernia, etc.), and which are a normal, foreseeable result of the sport, are not covered. These items are considered a sickness and are not covered.

## **DESCRIPTION OF BENEFITS**

All benefits payable are shown in the Schedule of Benefits.

## 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, 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 Covered Losses due to the same Covered Accident.

### Schedule of Covered Losses

<u>Loss of:</u>	<u>Benefit:</u> (Percentage of Principal Sum)
Life .....	100%
Two or More Members .....	100%
One Member.....	50%

“Member” means Loss of Hand or Foot, Loss of Arm or Leg, 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 Arm or Leg” means complete Severance through or above the elbow or knee joint. “Loss of sight” means total and permanent loss of sight of one/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.

## 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 below and 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 Covered Expenses incurred within 365 days after the date of the Covered Accident.

No benefits will be paid for any expenses incurred that are 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) Ancillary Hospital expenses: services and supplies including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) when Hospital Confined.
- 3) Daily Intensive Care Unit/Cardiac Care Unit Expenses: the daily room rate when a Covered Person is Hospital confined in a bed in the Intensive Care Unit/Cardiac Care Unit and nursing services other than private duty nursing services.
- 4) Registered Nurse Services Expenses for private duty nursing while a Covered Person is Hospital Confined, when services are ordered by a Physician.
- 5) Medical Emergency Care (room and supplies) expenses 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.
- 6) Outpatient surgery expenses, including Ambulatory Surgical Center.

- 7) Outpatient surgical room and supply expenses for use of the surgical facility.
- 8) Outpatient diagnostic x-rays, laboratory procedures and test expenses.
- 9) 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.
- 10) Second surgical opinion expenses.
- 11) 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.
- 12) Assistant Surgeon expenses when Medically Necessary.
- 13) Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
- 14) Outpatient laboratory test expenses.
- 15) Physiotherapy (physical medicine) 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, chiropractic, adjustments, manipulation, massage or any form of physical therapy.
- 16) Post surgical physical medicine expenses and office visits connected with such treatment when prescribed by a Physician.
- 17) Diagnostic imaging expenses including magnetic resonance imaging (MRI) and CAT scans.
- 18) 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.
- 19) Outpatient registered nurse services if ordered by a Physician.
- 20) Ambulance expenses for transportation from the Accident site to the Hospital.
- 21) Rehabilitative braces or appliances prescribed by a Physician. It must be durable medical equipment that is primarily and customarily used to serve a medical purpose and can withstand repeated use and 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.
- 22) Prescription drug expenses prescribed by a Physician and administered on an outpatient basis.
- 23) 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.
- 24) Medical services and supplies for blood and blood transfusions; oxygen and its administration.
- 25) Eyeglasses, contact lenses and hearing aids when damage occurs in a Covered Accident that requires medical treatment.
- 26) Artificial limbs, eyes and larynx for initial acquisition and fitting. We will not pay for repair or replacement of artificial limbs, eyes or larynx.

### **Terms of Payment for Accident Medical and Dental Expense Benefit**

#### **Full Excess:**

If a Covered Person incurs Covered Expenses, We will pay the applicable benefit, subject to any applicable Deductible, Coinsurance Factor and Benefit Period shown on the Schedule of Benefits that are in excess of expenses 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.

Failure by a Covered Person to follow the terms and conditions and/ or failure to utilize the network providers and facilities of His primary coverage will result in a benefit reduction of Covered Expense to 50% of the amount otherwise payable under the Policy. This limitation will not apply to emergency treatment required within 24 hours

after an Accident when the Accident occurs outside the geographic area served by His primary plan's HMO, PPO or other similar arrangement for provision of benefits or services, if applicable.

For the purposes of this provision, "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).

### **EXCLUSIONS**

This Policy does not cover any loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of any of the following even if the immediate cause of the loss is an accidental bodily Injury, unless otherwise covered under this policy by Additional Benefits:

1. Suicide, self-destruction, attempted self-destruction or intentional self-inflicted Injury while sane or insane.
2. War or any act of war, declared or undeclared.
3. Service 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 or any bacterial infection, except one that results from an accidental cut or wound or pyogenic infections that result from accidental ingestion of contaminated substances.
5. Voluntarily taking any drug or narcotic unless the drug or narcotic is prescribed by a Physician.
6. Covered Expenses for which the Covered Person would not be responsible in the absence of this Policy.
7. Injuries paid under Workers' Compensation, Employer's liability laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.
8. Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.
9. Services or treatment rendered by a Physician, Nurse or any other person who is employed or retained by the policyholder; or an Immediate Family member of the Covered Person.
10. Treatment of a hernia whether or not caused by a Covered Accident.
11. Treatment of Osgood-Schlatter's disease, osteochondritis, appendicitis, osteomyelitis, cardiac disease or conditions, pathological fractures, congenital weakness, whether or not caused by a Covered Accident.
12. Damage to or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in this Policy.
13. Eyeglasses, contact lenses, hearing aids.
14. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
  - While riding as a passenger in any aircraft not intended or licensed for the transportation of passengers

### **CLAIMS PROVISIONS**

**NOTICE OF CLAIM:** Written notice of death or Injury must be given to the Company within 30 days after a Covered Loss begins or as soon as reasonably possible. Notice can be given to the Company at Berkley Accident and Health, 2445 Kuser Road Suite 201, Hamilton Square NJ 08690, Attn: Claims Department. Notice should

include the Covered Person's name and address as well as this Policy Number. If written notice is not received within 30 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

- 1) it can be shown that it was not possible within reason to submit notice within the 30 day period; and
- 2) it is further shown that notice was given as soon as possible.

**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 after receipt of such notice, Proof of Loss requirements stated below will be deemed to have been met if, within the Proof of Loss time period specified below, written proof of the nature and extent of the loss is submitted.

**PROOF OF LOSS:** Written proof of loss must be given to the Company within 180 days after the date of loss. If the proof of loss is not submitted within 180 day, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

- 1) it can be shown that it was not possible within reason to submit notice within the 180 day period; and
- 2) it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

**TIME OF PAYMENT OF CLAIMS:** Benefits for loss covered by this Policy, other than benefits that require periodic payment, will be paid as soon as the Company receives proper written proof of such loss. Benefits for loss covered by this Policy that require periodic payment shall be paid monthly provided that the Company receives proper written proof of such loss.

**PAYMENT OF CLAIMS:** All benefits will be paid in United States currency. Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of this Policy entitled 'General Policy Provisions'. To receive proceeds, a beneficiary must be living on the earlier of the following dates: the date the Company receives proof of the loss of life; or the 10<sup>th</sup> day after the death.

All other benefits will be paid to the Covered Person suffering the loss. If the Covered Person dies before all payments due have been made, the amount still payable will be paid to his/her beneficiary as described in the Designation and Change of Beneficiary provision of this Policy entitled 'General Policy Provisions'.

**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.

**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) Reduction of any proceeds payable under this Policy by the amount overpaid or paid in error.

**SUBROGATION:** The Policyholder is required to investigate and prosecute all valid claims that it may have against third parties arising out of any claim for which benefits were paid by this Policy. The Policyholder shall account to the Company for all amounts recovered. If the Policyholder fails to pursue any action against a third party and the Company has made benefit payments under this Policy, the Company will be subrogated to all of the Policyholder's rights to make recoveries. However, the Company's Subrogation right is secondary to the Policyholder's right to be fully compensated for its damages. The Policyholder is required to cooperate fully and do all things necessary and required for the Company to pursue any action to recover against the third party; the scope of the Policyholder's cooperation shall include, without limitation, the execution of a Subrogation receipt or assignment in favor of the Company and the granting of authorization to the Company to commence litigation or other legal proceedings in the name of the Policyholder to seek recoveries from third parties. The Company agrees to pay its portion of the Policyholder's attorneys' fees or other costs associated with a claim or lawsuit to the extent that the Company recovers any portion of the benefits paid under this Policy pursuant to its Subrogation right.

## GENERAL POLICY PROVISIONS

**ENTIRE CONTRACT/CHANGES:** This Policy and all endorsements, amendments and attached papers is the entire contract between the Policyholder and the Company.

Changes to this Policy may be made at any time by an endorsement or amendment and must be agreed upon, in writing, between the Policyholder and the Company. 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/or any state or other federal law or regulation. No agent may change this Policy or waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** In the absence of fraud, all statements made by the Policyholder or by a Covered Person shall be deemed representations and not warranties. No such statement shall be used to contest this Policy or reduce benefits unless contained in a signed, written application, a copy of which has been provided to the person who made the statement, or to their beneficiary or representative. No such statement will be used to contest this Policy after this Policy has been in force for two years.

**ARBITRATION:** All disputes between the Policyholder and the Company shall be settled by arbitration in accordance with the Commercial Rules of the American Arbitration Association, except with regard to rules governing the selection of arbitrators. It is further stipulated that the arbitrator(s) shall, when adjudicating any dispute under this Policy, consider the terms and conditions of this Policy, applicable substantive law, and may, in the arbitrators' discretion, consider applicable custom and practice in the Accident and Health industry. All matters shall be decided by a panel of three (3) arbitrators, all of whom must be either current or former officers or directors of Life, Health and Accident insurers or current or former insurance brokers or administrators with substantial experience in the. Each party shall select its own party arbitrator and the parties' chosen arbitrators shall jointly select the third; in the event that the two party-arbitrators cannot agree on the third arbitrator, each party shall appoint three candidates, two of whom shall be stricken by the other party, and the third arbitrator shall thereafter be chosen from the remaining two candidates by the drawing of lots. Judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction. This provision shall survive the termination or expiration of this Policy. The arbitrators shall have no power or authority to award punitive or exemplary damages. Any arbitration shall be confidential, and except as required by law, neither party may disclose the existence, content or results of any arbitration hereunder without the prior written consent of the other parties, except that disclosure is permitted to a party's auditors and legal advisors. The parties hereto may alter any of the terms of this provision only by express written agreement, although such alteration may be before or after any rights or obligations arise under this provision. This provision will survive the termination or expiration 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.

**CONFORMITY WITH STATE STATUTES:** Any provision of this Policy in conflict on its effective date with the laws of the State of Issue indicated on the front page of this Policy is amended to conform to the minimum requirements of such laws.

**DESIGNATION OR CHANGE OF BENEFICIARY:** Each Covered Person may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order of preference:

- 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;
- 3) In equal shares to the members of the first surviving class of those that follow, if any:
  - a) a Covered Person's lawful spouse, if not legally separated or divorced, or Domestic Partner;

- b) a Covered Person's natural Child, adopted Child, foster Child, stepchild, or other Child for whom the Covered Person has or had legal guardianship (proof will be required); or
  - c) a Covered Person's parents, whether natural, step or adoptive; otherwise.
- 4) The estate of the Covered Person.

A Covered Person may change his/her beneficiary designation from time to time without the consent of the designated beneficiary by giving notice, in writing, to the Policyholder. When a request for designation or change is received by the Policyholder, it will take effect on the date of its execution, whether or not the Covered Person is living on the date it is received by the Policyholder. Any interest created by the request will be subject to any payment made or action taken before its receipt.

A Dependent's beneficiary is the Covered Person. If no beneficiary is living on the date of a Dependent's death, the beneficiary is the Covered Person's estate.

**ASSIGNMENT:** 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.

**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 this Policy.

**LEGAL ACTION:** 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 within 60 days after written Proof of Loss has been furnished. No legal action may be brought after three (3) years from the time written Proof of Loss is required to be furnished.

**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.

**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 in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.

**SCHEDULE OF BENEFITS**

**POLICYHOLDER:** Envision Performing Arts, Inc.

**POLICY EFFECTIVE DATE:** 12/1/2011

**POLICY NUMBER:** PAI L00225053-001

**PREMIUM DUE DATE:** Annual in advance

**POLICY PERIOD:** 12/01/11 - 12/01/12

**CLASSES OF ELIGIBLE PERSONS:**

Class 1 All Participants and Staff of the Policyholder's Winterguard Activities

**PREMIUMS** – \$135.00

**HAZARDS INSURED AGAINST:**

<u>Class</u>	<u>Description of Hazard</u>
Class 1	Sports Coverage

**Covered Activity(ies):** Winter Guard Activities

**ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS**

<b>Class 1 Principal Sum:</b>	\$10,000.00
<b>Time Period for Loss:</b>	365 days from the date of the Accident

**ACCIDENT MEDICAL AND DENTAL EXPENSE BENEFIT**

<b>Total Benefit Maximum for all Accident Medical:</b>	\$10,000.00
<b>Loss Period (first Covered Expenses must be incurred within):</b>	90 days after the Covered Accident.
<b>Benefit Period:</b>	1 Year
<b>Deductible:</b>	\$250.00
<b>Coinsurance Factor for all Covered Expenses</b>	100% of Usual & Customary
<b>Terms of Payment</b>	Full Excess

Accident Medical Expense benefits may be available on an allocated or unallocated basis as shown, that is to say there may be specific limits or coinsurance rates on certain Covered Expenses (allocated) or all Covered Expenses may be subject to the same maximum limit and coinsurance factor (unallocated).

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

# Berkley Life and Health Insurance Company

Urbandale, Iowa

Administrative Office:2445 Kuser Road, Suite 201, Hamilton Square, NJ 08690

**A Berkley Company**

## **NEVADA RIDER**

This Rider is attached to and made a part of PAI L00225053-001 issued to Envision Performing Arts, Inc.. The Policy/Certificate are hereby amended for Nevada as follows:

### **DEFINITIONS**

The definition of **MEDICALLY NECESSARY** is replaced with the following:

**MEDICALLY NECESSARY** means health care services or products that a prudent Physician would provide to a patient to prevent, diagnose or treat an Injury, or any symptoms thereof, that are necessary and:

- 1) provided in accordance with generally accepted standards of medical practice;
- 2) clinically appropriate with regard to type, frequency, extent, location and duration;
- 3) not primarily provided for the convenience of the patient, Physician or other provider of health care;
- 4) required to improve a specific health condition of a patient or to preserve his existing state of health; and
- 5) the most clinically appropriate level of health care that may be safely provided to the patient.

### **TERMINATION DATE OF INSURANCE**

The following is added:

We will provide written notice at least 60 days prior to any action by Us to cancel, non-renew or renew coverage with altered terms. If renewal is with altered terms We will provide any change in rate by line of coverage.

The following provision is added:

#### **Continuation of Coverage When Totally Disabled**

If the Covered Person is on leave without pay as a result of a Total Disability, coverage will be continued for the Covered Person and any Covered Dependents who are otherwise covered by the Policy. Such coverage will be for any Injury suffered:

1. By the Covered Person which is not related to the condition causing the Total Disability; and
2. By the Covered Person's Covered Dependents.

Coverage will continue while the Covered Person is on such leave until the earlier of the following events to occur:

1. The date on which the Covered Person's employment is terminated;
2. The date on which the Covered Person obtains coverage under another health insurance policy;
3. The date on which the Covered Person's certificate is terminated;
4. 12 months from the date this continuation began.

### **Changes in Premium Rate**

The first sentence of the Changes in Premium Rates provision is revised as follows:

The Company may change the premium rates from time to time with at least 60 days advanced written or authorized electronic notice.

## **DESCRIPTION OF BENEFITS**

The following benefit shall always be included in the list of Covered Medical Expenses under the Accident Medical and Dental Expense Benefit, subject to the same terms and conditions:

- 1) Charges of a Home Health Care Agency for the Medically Necessary treatment and care under a Home Health Care Plan for health supportive services when such services are provided in lieu of continued Hospital confinement. Up to 4 consecutive hours in a 24 hour period of home health care services are considered as one home health care visit. Benefits are limited to 60 visits in any one policy year.

"Home Health Care Agency" means an entity licensed by state or local law operated primarily for the purpose of providing skilled nursing care and therapeutic services in a person's home and: a) which maintains clinical records on each patient; b) whose services are under the supervision of a Physician; and c) which maintains operational policies established by a professional group including at least one Physician and one nurse.

"Home Health Care Plan" means a program for continued care and treatment of a person. It must be established and approved in writing by the Physician. Care under the Plan must begin within 14 days after Hospital confinement for the same Injury. An attending Physician must certify that proper treatment of the Injury would require continued confinement in a Hospital in the absence of the services and supplies as a part of the Plan.

## **EXCLUSIONS**

No Exclusion pertaining to alcoholism, drug addiction, being intoxicated or under the influence of any drug or narcotic, or the use of alcohol, drugs, narcotics, medicines or controlled substances shall apply in Nevada. The following exclusions are removed in Nevada:

Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.

## **CLAIMS PROVISIONS**

The TIME OF PAYMENT OF CLAIMS provision is replaced with the following:

We will approve or deny all claims within 30 days after satisfactory written proof of loss is received. The claim will be paid within 30 days after it is approved. If it is not paid within this time, interest will be paid on the claim at the rate of interest established pursuant to NRS 99-040 unless a different rate of interest is established pursuant to an express written contract between Us and the provider. The interest will be calculated from the date the payment was due until the claim is paid.

If We need additional information to determine whether to approve or deny the claim, the Covered Person will be sent a written notice within 20 days of receipt of proof of loss, explaining why more time is needed. The provider of the health care will also be notified of the reason for the delay. In this case, the decision on the claim will then be made within 30 days of receipt of the additional information. If the claim is approved it will be paid within 30 days after the additional information is received. If it is not paid within this time interest on the claim will be paid as stated in the preceding paragraph.

The following is added to the PAYMENT OF CLAIMS provision:

We will reimburse directly any provider of covered medical transportation for eligible expenses as long as reimbursement is not received from any other source. The Covered Person or the provider of the service may submit the claim.

**GENERAL POLICY PROVISIONS**

The ENTIRE CONTRACT/CHANGES provision is replaced with the following:

**ENTIRE CONTRACT/CHANGES:** The Policy and this Certificate and all endorsements, amendments and attached papers is the entire contract between the Policyholder and the Company.

Changes to the Policy and this Certificate may be made at any time by an endorsement or amendment and must be agreed upon, in writing, between the Policyholder and the Company. The Company may also, upon 60 days written notice to the Policyholder, change or modify the provisions of the Policy and this Certificate to comply with any applicable requirements of the Internal Revenue Service and/or any state or other federal law or regulation. No agent may change the Policy and this Certificate or waive any of its provisions.

Signed for the Company:



President



Secretary

## Nevada Guaranty Notice

Section 686C.128 of the Nevada Insurance Code requires all Group Life and Health insurers to provide a summary of the basic provisions of the Nevada Life and Health Insurance Guaranty Association Act.

Any questions concerning this summary should be directed to the Nevada Life and Health Insurance Guaranty Association or to the Nevada Insurance Department at the addresses contained in the summary.

### NEVADA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

#### GUARANTY ASSOCIATION ACT SUMMARY DOCUMENT

Residents of Nevada who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in the state to write these types of insurance are members of the Nevada Life and Health Insurance Guaranty Association (Association). The purpose of the Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insured becomes financially unable to meet its obligations. If this should happen, the Association assesses its other member insurance companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Association is not unlimited, however, and, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

**The Nevada Life and Health Insurance Guaranty Association may not provide coverage for a policy. If coverage is provided, it will be subject to substantial limitations and exclusions, and require continued residency in Nevada. A person should not rely on coverage by the Nevada Life and Health Insurance Guaranty Association when selecting an insurance company or when selecting an insurance policy.**

Coverage is NOT provided for a policy or any portion of it that is not guaranteed by the Insurer or for which the policyholder has assumed the risk, such as a variable contract sold by prospectus.

Insurance companies are required by law to deliver this notice to you. **However, insurance companies and their agents are prohibited by law from using the existence of the Association for sales, solicitation or to induce the purchase of any kind of insurance policy.**

The state law that provides for this safety-net coverage is called the Nevada Life and Health Insurance Guaranty Association. Below is a brief summary of this law's coverages, exclusions and limits. The summary does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations under the act, or the rights or obligations of the Association. **Anyone may obtain additional information from the Association or file a complaint with the Commissioner of Insurance to allege a violation of any provision of the Nevada Life and Health Insurance Guaranty Association Act, at the applicable address listed below:**

**The Nevada Life and Health Insurance Guaranty Association  
P. O. Box 3302  
Reno, Nevada 89505**

**Nevada Commissioner of Insurance  
Department of Business and Industry  
Division of Insurance  
1818 E. College Parkway, Suite 103  
Carson City, Nevada 89706**

## **COVERAGE**

Generally, individuals will be protected by the Association if they live in this state and **hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract issued by a member insurer.** The beneficiaries, payees or assignees of the insured persons are protected as well, even if they live in another state.

## **EXCLUSIONS FROM COVERAGE**

However, persons holding such policies are **NOT** protected by this Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside the state);
- the insurer was not authorized to do business in this state; or
- their policy was insured by a nonprofit hospital or medical service organization, a health maintenance organization (HMO), a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does **NOT** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them); and
- unallocated annuity contracts (which give rights to group contract holders, not individuals) other than an annuity owned by a governmental retirement plan established under section 401, 403(b) or 457 of the Internal Revenue Code 26 U.S.C. §§ 401, 403(b) and 457, respectively, or trustees of such a plan.

## **LIMITS ON AMOUNT OF COVERAGE**

The act also limits the amount the Association is obligated to pay. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of \$300,000, regardless of how many policies and contracts there were with the same company, and even if they provided different types of coverage. Within this overall \$300,000 limit, the Association will not pay more than: (1) \$100,000 in cash surrender values; (2) \$100,000 in present value of an annuity; or (3) \$300,000 in life insurance death benefits.

With respect to health insurance for any one natural person, the Association will not pay more than: (1) \$100,000 for coverages other than disability insurance, basic hospital, medical and surgical insurance or major medical insurance, including any net cash for surrender or withdrawal; (2) \$300,000 for disability insurance; or (3) \$500,000 for basic hospital, medical and surgical insurance or major medical insurance.

With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, the Association will not pay more than \$100,000 in present values of benefits from the annuity in the aggregate, including any net cash for surrender or withdrawal.

With respect to any one life or person, in no event will the Association be obligated to cover more than: (1) an aggregate of \$300,000 in benefits, excluding benefits for basic hospital, medical and surgical insurance or major medical insurance; or (2) an aggregate of \$500,000 in benefits, including benefits for basic hospital, medical or surgical insurance or major medical insurance.

With respect to one owner of several non-group policies of life insurance, whether the owner is a natural person or an organization and whether the persons insured are officers, managers, employees or other persons, the Association will not pay more than \$5,000,000 in benefits, regardless of the number of policies and contracts held by the owner.

With respect to each participant in a governmental retirement plan covered by an unallocated annuity contract as described in chapter 686C of the Nevada Revised Statutes, the Association will not pay more than an aggregate of \$100,000 regardless of the number of contracts issued by any single member company.

**FOR MORE INFORMATION AND ANSWERS TO THE MOST FREQUENTLY ASKED QUESTIONS, PLEASE VISIT THE ASSOCIATION'S WEB SITE: [www.nvlifega.org](http://www.nvlifega.org)**

## **BERKLEY LIFE AND HEALTH INSURANCE COMPANY PRIVACY NOTICE**

Berkley Life and Health Insurance Company (the “Company”), a member company of the W. R. Berkley Corporation (“Berkley”) group of companies and each other member of the Berkley group of companies (“Affiliates”) understands our customers’ concern about privacy of their information collected by the Company. Our Company is dedicated to protecting the confidentiality and security of nonpublic personal information we collect about our customers in accordance with applicable laws and regulations. This notice refers to the Company by using the terms “us,” “we,” or “our.” The law requires that we send you a notice describing our privacy policy and how we treat the nonpublic personal information about our customers that we receive in connection with our business (Information”).

### **Why We Collect and How We Use Information.**

We collect and use Information for business purposes with respect to our insurance products and services and other business relations involving our customers. We gather this Information to evaluate your request for insurance, to evaluate your insurance claims, to administer, maintain or review your insurance policy, and to process your insurance transactions. We also accumulate certain information about you as may be required or permitted by law.

Your insurance agent or broker also collects this Information and may use it to help with your overall insurance program or to market additional products and services to you. We may also use Information to offer you other products or services that we or our Affiliates provide.

### **How We Collect Information.**

Most Information collected by us is provided by you or your insurance agent or broker to us. We obtain Information from (i) applications or other forms submitted by you, your insurance agent or broker or your authorized representatives to us and our Affiliates, and (ii) your transactions with us or our Affiliates. We may also obtain Information from other sources such as (i) consumer reporting agencies, (ii) other institutions or information services providers, (iii) employers, (iv) other insurers, or (v) your family members.

### **Information We Disclose.**

We disclose any Information which we believe is necessary to conduct our business as permitted by applicable law or where required by applicable law. This disclosure may include (i) Information we receive from you on applications or other forms provided to us and our Affiliates, such as names, addresses, social security numbers, assets, employer information, salaries, etc. (ii) Information about your transactions with us and our Affiliates, such as policy coverages, premiums, payment history, etc., and (iii) Information we receive from a consumer reporting agency, such as credit worthiness and credit history.

### **To Whom We Disclose Information.**

We may, as permitted or required by applicable law, disclose your Information to nonaffiliated third parties, such as (i) your insurance agent or broker, (ii) independent claims adjusters, (iii) insurance support organizations, (iv) processing companies, (v) actuarial organizations, (vi) law firms, (vii) other insurance companies involved in an insurance transaction with you, (viii) law enforcement, regulatory, or governmental agencies, (ix) courts or parties therein pursuant to a subpoena or court order, (x) businesses with whom we have a marketing agreement, or (xi) our Affiliates.

We may share Information with our Affiliates so that they may offer you products and services from the Berkley group of companies or to analyze our book of business and to consolidate necessary information. We do not disclose Information to other companies or organizations not affiliated with us for the purpose of using Information to sell their products or services to you. For example, we do not sell your name to unaffiliated mail order or direct marketing companies.

### **How We Protect Information.**

We require our employees to protect the confidentiality of Information as required by applicable law. Access to Information by our employees is limited to administering, offering, servicing, processing or maintaining of our products and services. We also maintain physical, electronic and procedural safeguards designed to protect Information. When we share or provide Information to other persons or organizations, we contractually obligate them, if required by law, to treat Information as confidential and conform to our privacy policy and applicable laws and regulations.

### **Correction and Access to Information.**

Upon our receipt of your written request to us at Berkley Life and Health Insurance Company, 475 Steamboat Road, Greenwich, Connecticut 06836-2519 we will, generally, make available Information for your review. If you believe the Information we have about you is incorrect or inaccurate, you may request that we make any necessary corrections, additions or deletions. If we agree with your belief, we will correct our records if required by applicable law. If we do not agree, you may submit to us a short statement of dispute, which we will include in any future disclosure by us of such Information if required by applicable law.

**Requirements for Privacy Notice.**

This privacy notice is being provided due to recently enacted federal and state laws and regulations establishing new privacy standards and requires us to provide this privacy policy. For additional information regarding our privacy policy, please write to us at 475 Steamboat Road, Greenwich, Connecticut 06836-2519.

Revised: February 7, 2006