ARCH INSURANCE COMPANY
(A Missouri Corporation)

Home Office Address:
2345 Grand Boulevard, Suite 900
Kansas City, MO 64108

Administrative Address:
Executive Plaza IV
11350 McCormick Road, Suite 102
Hunt Valley, MD 21031
Tel: 855-951-2329

CALIFORNIA BLANKET ACCIDENT POLICY

POLICYHOLDER	**William S. Hart Baseball & Softball League, Inc.**
POLICY NUMBER	**O2SPR00000146**
POLICYHOLDER ADDRESS	**23780 Auto Center Court, Santa Clarita, CA 91355**
POLICY EFFECTIVE DATE	**January 1, 2026**
POLICY TERM	**January 1, 2026 to January 1, 2027**

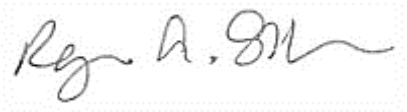
This Policy takes effect at 12:01 AM on the Policy Effective Date shown above at the address of the Policyholder. The Policy terminates at 11:59 PM on the last day of the Policy Term unless the Policyholder and the Company agree to continue coverage under this Policy for an additional Policy Term. If 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.



Regan A. Shulman
Secretary

Brian D. First
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 AN EXCESS PROVISION.

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POLICYHOLDER	**William S. Hart Baseball & Softball League, Inc.**
POLICY NUMBER	**O2SPR00000146**
POLICY EFFECTIVE DATE	**January 1, 2026**
POLICY PERIOD	**January 1, 2026 to January 1, 2027**
PREMIUM DUE DATE	**ANNUAL IN ADVANCE**

CLAIMS ADMINISTRATOR

Arch Insurance Company
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 and enrolled participants of the Policyholder while engaging in a Covered Activity.

PREMIUMS

$4,685

AGGREGATE LIMIT OF LIABILITY

Benefit Maximum	$500,000
Applies During	per Covered Accident
Applies To	Accidental Death & Dismemberment benefits only

COVERED ACTIVITIES

The following are the Covered Activities for which insurance applies:

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

Covered Activities:
While participating in the following Policyholder supervised and sponsored activities:
Baseball (League and/or Club), Softball (League and/or Club)

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 Principal Sum:	$10,000
Time Period for Loss:	365 days
Exposure and Disappearance:	Included

ACCIDENT MEDICAL DENTAL EXPENSE BENEFIT

Total Benefit Maximum for all Accident Medical and Dental Expense Benefits	$100,000 per Covered Accident
First Covered Expenses must be incurred within	90 days after the covered Accident
Benefit Period	1 year from the date of the covered Accident
Scope of Coverage	Full Excess

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

Covered Expense

Daily Hospital Room and Board

Daily Intensive Care Unit

Ancillary Hospital Expenses

Physician Office Visit

Physician Surgical Expenses

Emergency Room and Supplies

Ambulance

Outpatient Surgery Visit

Outpatient Surgical Room and Supplies

Outpatient Laboratory Tests and X-Rays

Physical Medicine

Anesthesiologist Expenses

Dental Expenses

Rehabilitative Braces and Appliances

Prescription Drugs

Medical Equipment Rental

Medical Services and Supplies

Eyeglasses, or Contact Lens and Hearing Aids

Artificial Limbs

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:

1. designated or furnished by the Policyholder, operated by a properly licensed adult driver who is under the direct supervision of the Policyholder; and
2. travel time does not exceed 1 hour each way.

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 happening by chance that arises from an external source to the Covered Person and occurs at an identifiable time and place.

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 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.

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.

HOSPITAL CONFINED means a stay of 24 or more consecutive hours as a registered resident bed-patient in a Hospital.

IMMEDIATE FAMILY means the Insured'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.

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) appropriate and consistent with the patient's diagnosis;
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 ceases to be eligible as described in this Policy provided all required premiums are paid; or
4) The last day of the period for which premiums have been paid.

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 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%
Quadriplegia	100%
Two or More Members	100%
One Member	50%
Hemiplegia	50%
Paraplegia	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.

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 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;
2) for those Medically Necessary Covered Expenses incurred by or on behalf of the Covered Person;
3) for charges incurred within the timeframe shown on the Schedule of Benefits 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) 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) 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.
15) Prescription drug expenses prescribed by a Physician and administered on an outpatient basis.
16) 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.
17) Medical services and supplies for blood and blood transfusions; oxygen and its administration.
18) Eyeglasses; contact lenses; and hearing aids when damage occurs in a Covered Accident that requires medical treatment.
19) Artificial limbs; eyes; and larynx for initial acquisition and fitting. We will not pay for repair or replacement of artificial limbs; eyes; or larynx.

SECTION VIII – SCOPE OF COVERAGE

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

Full Excess Benefits

If a Covered Person incurs Covered Expenses, We will pay the applicable benefit, subject to any applicable 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.

Failure by a Covered Person to follow the terms and conditions of his or her 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 a Covered Accident. Such Covered Accident must occur outside the geographic area served by the primary plan's HMO, PPO or other similar arrangement for provision of benefits or services, if applicable.

"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. 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.
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
A grace period of 31 days will be granted for the payment of premiums accruing after the first premium, during which grace period the policy shall continue in force, but the Policyholder shall be liable to the insurer for the payment of the premium accruing for the period the policy continues in force.

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.

SECTION X - CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the insurer at our claims office noted on Section I - Schedule of Benefits or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

CLAIM FORMS: The insurer, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

PROOF OF LOSS: Written proof of loss must be furnished to the insurer, in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which the insurer is liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the insured, later than one year from the time proof is otherwise required.

BENEFICIARY: The Covered Person may designate a beneficiary. The right to change of beneficiary is reserved to the Insured, and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary.

EXPOSURE AND DISAPPEARANCE: If, by reason of a covered accident, a Covered Person is unavoidably exposed to the elements and as the result of such exposure suffers a loss for which indemnity is otherwise payable, such loss will be covered under the terms of the Policy.

If the body of a Covered Person has not been found within 1 year after the date of disappearance as the result of the sinking or wrecking of the aircraft or watercraft in which the Covered Person was riding at the time of the accident and under such circumstances as would otherwise be covered, it will be presumed that the Covered Person suffered loss of life resulting from Injury caused solely by a Covered Accident.

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Insured.

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: Subject to due written proof of loss, all indemnities for loss for which this policy provides payment will be paid as they accrue and any balance remaining unpaid at termination of the period of liability will be paid immediately upon receipt of due written proof.

PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as it may reasonably require during the Pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

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: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which this policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statute.

ENTIRE CONTRACT/CHANGES: This policy and the application of the Policyholder constitute the entire contract between the parties, and any statement made by the Policyholder shall, in the absence of fraud, be deemed a representation and not a warranty. No statement made by any Policyholder whose eligibility has been accepted by the insurer shall void the insurance or reduce the benefits under this policy or be used in defense to a claim hereunder.

After two years from the date of issue of this policy, no misstatement of the Policyholder, except a fraudulent misstatement, made in its application shall be used to void the policy; and after three years from the effective date of the coverage with respect to which any claim is made no misstatement of any insured eligible for coverage under the policy, except a fraudulent misstatement, made in an application under the policy shall be used to deny a claim for loss incurred or disability (as defined in the policy) commencing after expiration of such three years.

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: After two (2) years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for the policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of the two (2) year period.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

MAXIMUM BENEFIT means the largest total amount of Covered Expenses that We will pay for the Insured.

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; terms; or conditions for coverage, the Company will have the right to revise the rates; 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. War or any act of war or invasion; declared or undeclared.
4. 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.
5. Sickness; disease; mental infirmity; bodily malfunctions; 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.
6. Piloting or serving as a crewmember or riding in any aircraft except as a fare-paying passenger on a regularly scheduled or charter airline.
7. Intoxication or being under the influence of any controlled substance unless administered on the advice of physician. Intoxication is defined by the laws of the jurisdiction where such Accident occurs.
8. The commission of or attempt to commit a felony by the person whose injury or sickness is the basis of claim, or to which a contributing cause was such person's being engaged in an illegal occupation.
9. 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.
10. Travel or activity outside the United States.
11. Participation in any motorized vehicular race or speed contest.
12. A Covered Accident if the Covered Person is the operator of a motor vehicle; and does not possess a valid motor vehicle operator's license.
13. To the extent We are prohibited from providing coverage or making payment by any type of travel restriction; trade restriction; economic sanction; or embargo imposed by the U.S. government.

14. Actively participating in acts of terrorism, civil commotion or riots of any kind.
15. 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 piloting; operating; learning to operate; or serving as a member of the crew thereof.

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

1. Persons employed or retained by a Policyholder; or by any Immediate Family; or member of the Covered Person's household.
2. 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 unless caused by Injury; Osgood-Schlatter's Disease; osteochondritis; appendicitis; osteomyelitis; cardiac disease or conditions; pathological fractures; congenital weakness; 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. Mental and Nervous Disorders (except as provided in the Policy).
5. Damage to or loss of dentures or bridges; or damage to existing orthodontic equipment (except as specifically covered by the Policy).
6. Expense incurred for treatment of temporomandibular; or craniomandibular joint dysfunction; and associated myofacial pain (except as provided by the Policy).
7. Any elective treatment; surgery; health treatment; or examination; including any service; treatment; or supplies that: (a) are experimental; and (b) are not recognized and generally accepted medical practices in the United States.
8. Expenses payable by any automobile insurance policy without regard to fault. (This exclusion does not apply in any state where prohibited).
9. Treatment of Injuries that result over a period of time (such as blisters; tennis elbow; etc.), and that are a normal result of participation in the Covered Activity.
10. Treatment or service provided by a private duty nurse.
11. Replacement of artificial limbs; eyes; and larynx.
12. Blood, blood plasma; or blood storage; except expenses by a Hospital for processing or administration of blood.
13. Cosmetic surgery; except for reconstructive surgery needed as the result of an Injury.
14. Eyeglasses; contact lenses; hearing aids; wheelchairs; braces; appliances; examinations or prescriptions for them; or repair or replacement of existing artificial limbs; orthopedic braces; or orthotic devices.

ARCH INSURANCE COMPANY
(A Missouri Corporation)

CALIFORNIA AMENDATORY RIDER

This Rider is attached to and made part of the Policy and any Certificate issued therewith. It is subject to all of the Policy provisions that do not conflict with its provisions.

1. Under Section X – **CLAIMS PROVISIONS**

   The following mandatory provision has been added to the policy and certificate

MEDICAL REVIEW REQUIREMENTS
A Covered Person may request an independent medical review ("IMR") of disputed health care services from the California Department of Insurance if he or she believes that we have improperly denied, modified, or delayed health care services. A disputed health care service is any health care service eligible for coverage and payment under the Covered Person's coverage that has been denied, modified, or delayed by us, in whole or in part because the service is not Medically Necessary.
The IMR process is in addition to any other procedures or remedies that may be available. There is no application or processing fee of any kind for an IMR. The Covered Person has the right to provide information in support of the request for an IMR. We must provide the Covered Person with an IMR application form together with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause a Covered Person to forfeit any California statutory right to pursue legal action against us regarding the disputed health care service. It should be noted that we do not believe any such California statutory right exists which is applicable to it.
For more information regarding the IMR process, or to request an application form, please contact us.
Eligibility.
The California Department of Insurance will review the Covered Person's application for an IMR to confirm that:
1. a. The provider has recommended a health care service as Medically Necessary.
   b. The Covered Person has received urgent care or emergency services that a provider determined was Medically Necessary; or
   c. The Covered Person has been seen by a provider for the diagnosis or treatment of the medical condition for which he or she seeks independent review.
2. The disputed health care service has been denied, modified, or delayed by us based in whole or in part on a decision that the health care service is not Medically Necessary; and
3. The Covered Person filed a grievance with us and the disputed decision is upheld or the grievance remains unresolved after 30 days. If the grievance requires expedited review, the Covered Person may bring it immediately to the attention of the California Department of Insurance. It may waive the requirement that the Covered Person follow the plan's grievance process in extraordinary and compelling cases.
If a case is eligible for an IMR, the dispute will be submitted to a medical specialist who will make an independent determination as to whether or not the care is Medically Necessary. The Covered Person will receive a copy of the assessment made. If the IMR determines the service is Medically Necessary, we will provide benefits for the health care service.
For non-urgent cases the IMR organization designated by the California Department of Insurance must provide its determination within 30 days of receipt of the Covered Person's application and supporting documents. For urgent cases involving imminent and serious threat to a Covered Person's health including, but not limited to, serious pain, the potential loss of life, limb or major bodily function, or the immediate and serious deterioration of the Covered Person's health, the IMR organization must provide its determination within three business days.

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

Regan A. Shulman
Secretary

Brian D. First
President

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Arch

Date Last Revised:
03/23/2021

FACTS

WHAT DOES ARCH DO WITH YOUR PERSONAL INFORMATION?

Why?

Financial companies (including insurance companies) choose how they share your personal information. Federal and state law gives consumers the right to limit some but not all sharing. These laws also require us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.

What?

The types of personal information we collect and share depend on the product or service you have with us. This information can include:

- Social Security number and credit history
- account balances and transaction and payment history
- insurance claim history and medical information

When you are *no longer* our customer, we continue to share your information as described in this notice.

How?

All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information, the reasons ARCH may choose to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does ARCH share?	Can you limit this sharing?
For our everyday business purposes — For example: to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes — to offer our products and services to you	Yes	No
For joint marketing with other financial companies	Yes	No
For our affiliates' everyday business purposes — information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes — information about your creditworthiness	No	We don't share
For our affiliates to market to you	No	We don't share
For nonaffiliates to market to you	No	We don't share

Questions?

- Call **1-844-812-2604**
- Email us at: ArchPrivacy@archinsurance.com

Who we are

Who is providing this notice?	Arch Insurance Company ("ARCH")

What we do

How does ARCH protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. ARCH: ▪ takes precautions to protect your information by implementing physical, electronic, and procedural safeguards; and ▪ uses security controls, including encryption, threat protection, and limits access to your information.
How does ARCH collect my personal information?	We collect your personal information, for example, when you: ▪ give us your contact information ▪ apply for insurance; ▪ pay insurance premiums ▪ file an insurance claim ▪ give us your income information We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.
Why can't I limit all sharing?	Federal laws give you the right to limit only: ▪ sharing for affiliates' everyday business purposes—information about your creditworthiness ▪ affiliates from using your personal information to market to you ▪ sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing. See below for more on your rights under state law.

Definitions

Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. ▪ For example, our affiliates include financial companies such as Arch Specialty insurance company.
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. ARCH does not share with nonaffiliates so they can market to you.
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. Our joint marketing partners include insurance agencies and travel companies.

Other important information

NOTICE OF INFORMATION PRACTICES

For residents of Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Montana, New Jersey, Nevada, North Carolina, Ohio, Oregon, and Virginia. These states require insurers and agents to describe their information practices in addition to providing a Privacy Notice. The two notices are very similar, but in general our information practices include the following: ARCH may obtain information about you and any other persons applying for insurance. Some of this information will come from you and some may come from other sources. That information and any other information collected by ARCH may in some circumstances be disclosed to third parties, such as agents, affiliates, service providers and others without your specific consent. In some cases, we may need your direct authorization before sharing that information. Residents have the right to access, to correct and, in some states, to delete (if incorrect) the information collected about them, except information that relates to a claim or to a civil or criminal proceeding. If you are refused coverage or if your application is postponed, you may also have the right to receive the specific reason in writing. To exercise your rights or if you wish to have a more detailed explanation of our information practices required by your state, please submit a written request by email to: ArchPrivacy@archinsurance.com. Additional information concerning our privacy policies can be found at https://www.archcapgroup.com/privacy-policy/ or call 844.812.2604.

STATE-SPECIFIC DISCLOSURES

Customer personal information will be collected, used, and stored as required by applicable federal privacy laws. If the Customer's state laws provide more protection of the Customer's personal information than federal privacy laws, ARCH will protect the Customer's personal information as required by such state law.

YOUR AUTHORIZATION REQUIRED

Arizona, California, Maine, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oregon, and Virginia. We will not share your personal information with non-affiliated third parties (or, in some circumstances, our affiliates) other than our agents or service providers unless you authorize us to share it or the law otherwise permits us to share it. You have the right to authorize or not authorize this sharing of personal information.

FOR VERMONT CUSTOMERS

We will not disclose information about your creditworthiness to our affiliates and will not disclose your personal information, financial information, credit report, or health information to nonaffiliated third parties to market to you, other than as permitted by Vermont law, unless you authorize us to make those disclosures. Additional information concerning our privacy policies can be found at https://www.archcapgroup.com/privacy-policy/ or call 844.812.2604.

ADDITONAL RIGHTS UNDER THE CALIFORNIA CONSUMER PRIVACY ACT (CCPA)

The California Consumer Privacy Act (CCPA) gives California residents certain privacy rights with respect to the limited non-public personal information we collect. These rights are:

- the right to notice of the personal information we collect;
- the right to know the categories, sources and specific pieces of personal information we have collected about you in the past 12 months, including our purpose for collecting the information and the categories of third parties with whom we share that personal information, subject to certain exceptions;
- the right to delete some or all of the personal information we collect, subject to certain exceptions; and
- the right to opt-out of our sale of your personal information, if we sell your personal information.

CCPA rights are limited and do not apply to any of the personal information (described on Page 1) that we have collected from you and about you in connection with providing you an insurance or financial product or service.

The personal information we collect that is subject to the CCPA includes some of your internet and network activity (such as your browsing history, Internet Protocol address and interactions with our website) and inferences drawn about you from this information, such as your preferences, aptitudes and abilities. We may share this information with our service providers for a business purpose. We do not sell personal information about current or former customers to any third parties. We may allow third-party advertising cookies to be placed on your browser or mobile device when you visit our website. You may opt-out of third party cookies. To learn how to exercise your rights under the CCPA or if you wish to see a more detailed explanation of your rights, please visit our website at https://www.archcapgroup.com and click on "Privacy and Data Protection Policy" on the home page or email us at: ArchPrivacy@archinsurance.com.

NEVADA DO-NOT-CALL REGISTRY

If you are a Nevada resident, the following Telemarketing Notice applies to you. We may contact you by phone to offer additional financial products and services that may be of interest to you. You may elect to include your phone number on our internal Do-Not-Call list if you do not wish to receive telemarketing calls from us. If your telephone number is included on the Do-Not-Call list, we may still contact you for servicing purposes.

To include your phone number on our Do-Not-Call list, please follow the instructions in the "To Limit Our Sharing" box on page 1 of this document. Nevada residents may also call the Nevada Attorney General for further information about these rights by calling toll free 1-888-434-9989.

U.S. TREASURY DEPARTMENT'S OFFICE OF FOREIGN ASSETS CONTROL ("OFAC") ADVISORY NOTICE TO POLICYHOLDERS

No coverage is provided by this Policyholder Notice nor can it be construed to replace any provisions of your policy. You should read your policy and review your Confirmation or Schedule of Benefits page for complete information on the coverages you are provided.

This Notice provides information concerning possible impact on your insurance coverage due to directives issued by OFAC. **Please read this Notice carefully.**

The Office of Foreign Assets Control (OFAC) administers and enforces sanctions policy, based on Presidential declarations of "national emergency". OFAC has identified and listed numerous:

- Foreign agents;
- Front organizations;
- Terrorists;
- Terrorist organizations; and
- Narcotics traffickers;

as "Specially Designated Nationals and Blocked Persons". This list can be located on the United States Treasury's web site – http://www.treas.gov/ofac.

In accordance with OFAC regulations, if it is determined that you or any other insured, or any person or entity claiming the benefits of this insurance has violated U.S. sanctions law or is a Specially Designated National and Blocked Person, as identified by OFAC, this insurance will be considered a blocked or frozen contract and all provisions of this insurance are immediately subject to OFAC. When an insurance policy is considered to be such a blocked or frozen contract, no payments nor premium refunds may be made without authorization from OFAC. Other limitations on the premiums and payments also apply.

California Guaranty Notice

NOTICE OF PROTECTION PROVIDED BY THE CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protection provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. Insurance Companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The valuable extra protection provided through the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions, and limit provided by the Association. This 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.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the California Life and Health Insurance Guarantee Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows:

Life Insurance, Annuities and Structured Settlement Annuity Benefits

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- **Life Insurance**

  80% of death benefits but not to exceed $300,000

  80% of cash surrender or withdrawal values but not to exceed $100,000

- **Annuities and Structured Settlement Annuities**

  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000.

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of polices or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741.This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The California Life and Health Insurance Guarantee Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract;
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;
- If the person is provided coverage by the guaranty association of another state;
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual;
- Employer and association plans, to the extent they are self-funded or uninsured;
- A policy or contract providing any health care benefits under Medicare Part C or Part D;
- An annuity issued by an organization that is only licensed to issue charitable gift annuities;
- 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 certain investment elements of a variable life insurance policy or a variable annuity contract;
- Any policy of reinsurance unless an assumption certificate was issued;
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(C)

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance Guarantee Association
P.O. Box 16860
Beverly Hills, CA 90209-3319
(323) 782-0182

or

Consumer Service Division
California Department of Insurance
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357 or (213) 897-8921

Insurance companies and their agents are not allowed by California law to use the existence of the Guarantee Association or its coverage to solicit, induce or encourage you to purchase any form of insurance policy. When selecting an insurance company, you should not rely on Association coverage. If there is an inconsistency between this notice and California law, then California law will control.