WELLFLEET INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

APPLICATION FOR PARTICIPANT ACCIDENT INSURANCE

1. Name of Policyholder: San Bernardino CCD (San Bernardino Valley, Crafton Hills)
2. Mailing Address: 701 S Mt Vernon Ave, San Bernardino, CA 92410
3. Policy Number: WI2526CAACC102 Plan Number:
4. Policy Effective Date: August 1, 2025 Policy Term Date: July 31, 2026
5. **Plan of Benefits:**

Policy Aggregate Maximum: Unlimited

Accidental Death and Dismemberment Benefit for Class 1, Class 2

Principal Sum Maximum Amount: $10,000

AD&D Aggregate Limit: $1,000,000

Exposure & Disappearance Coverage included: ☐ Yes ☒ No

Accident Medical Benefits

Class 1 Accident Medical Maximum: $25,000

Class 2 Accident Medical Maximum: $50,000

Accident Medical Coinsurance: 100%

Individual Offset: $0

Benefit Period: 52 weeks from date of covered accident

Treatment Window: 90 days

Other Benefits: Class 1 only

- Expanded Medical Coverage
  Covered Conditions: Bursitis, sprains, hernia, MRSA, muscle tears, tendonitis, stress fractures, shin splints, injury to joints and surrounding muscle and tissue, tennis elbow, and repetitive motion injuries.
- Heart/Circulatory Conditions
  Covered Conditions: heat exhaustion; heart attack, cardiac arrest, stroke, or burst aneurysm.
- Emergency Illness Expense Maximum Amount $1,000
- Re-Aggravation of Prior Injury Coverage
- Off-Season Conditioning Coverage: Yes ☐ No ☒
- Sojourn or Personal Deviations Coverage: Yes ☐ No ☒
- Recruit/Guest Coverage: Yes ☒ No ☐

6. **Plan Type:** Full Excess Medical
7. **Other Benefit Exclusions**: As defined by the Certificate.
8. **CLASSIFICATION TABLE**

Class	Eligible Class(es) of Covered Persons – Description of Class
1	**ICS-** All student athletes, student trainers, student managers and student coaches while participating in or attending any regularly scheduled practice or competition supervised by an authorized representative of the college; or While traveling directly to and from practices or competition with other members as a group, provided such travel is supervised by an authorized representative of the college.
2	**Registered Students-**FT- All degree seeking students, while attending regularly scheduled classes at college; First Responders (if applicable) or While attending college-sponsored activities, including club activities and other sports or traveling under college supervision to and from college sponsored events.

9. **List of Covered Activities/Sports (please specify)**: **ICS Sports Covered:**
Men's: Baseball, Basketball, Cross Country, Football, Soccer, Swimming & Diving, Track & Field, Water Polo
Women's: Basketball, Cross Country, Soccer, Softball, Swimming & Diving, Track & Field, Volleyball, Water Polo

10. **PREMIUM REPORT**

Total Premium Due	**$82,787**

Any policy issued by Wellfleet Insurance Company in consideration of this Application and payment of the first premium will include only those benefits shown in the proposal and agreed to by Us and the Applicant.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Signature of Policyholder	Position or Title	Date
	Executive Director, Bus & Fiscal SRVS	07/01/2025

Check if no agent is used: ☐

Agent/Broker Name: Student Insurance/ Venborook

Address:

Phone Number:

Email Address: Brenda McBride bmcbride@studentinsuranceusa.com

Tax I.D:

Signature of Agent/Broker	Date
Alison Myers	7/2/25

WELLFLEET INSURANCE COMPANY

5814 Reed Road Fort Wayne, Indiana 46835

CALIFORNIA FRAUD LANGUAGE ENDORSEMENT

This Endorsement is made a part of the application and enrollment form to which it is attached.

The following fraud statement, required by California Insurance Code 1871.2 effective January 1, 2023, is added to your application and enrollment form. This fraud statement replaces and takes precedence over any fraud statement in the application and enrollment form.

For your protection California law requires the following to appear on this form:

Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

This Endorsement is executed for the Company by its President and Secretary.

President
Andrew M. DiGiorgio

Secretary
Angela Adams

WELLFLEET INSURANCE COMPANY

5814 Reed Road Fort Wayne, Indiana 46835

BLANKET ACCIDENT INSURANCE POLICY

POLICYHOLDER:	San Bernardino Community College District (**Policyholder**, You, or Your)
POLICY NUMBER:	WI2526CAACC102
POLICY EFFECTIVE DATE:	August 1, 2025
POLICY TERM:	August 1, 2025 through July 31, 2026
STATE OF ISSUE:	California
POLICY ANNIVERSARY	August 1, 2026

The **Policy** is a legal contract between the **Policyholder** and Wellfleet Insurance Company (herein referenced as ("**We, Us, Our** and **Company**").

This **Policy** contains the terms under which the Insurance Company agrees to insure certain persons and pay benefits.

This **policy** takes effect on the **effective date** at 12:00 A.M. at the **policyholder'**s address**.** We must receive the **policyholder's** signed application and the initial **premium** for it to take place.

This **policy** terminates at 11:59 P.M. on the day following the last day of the **policy termination date** unless the **policyholder** and We agreed to continue coverage under this **policy** for an additional **policy term**.

Premium due dates
Premium is due on the **premium due date** immediately following the date We invoice You.

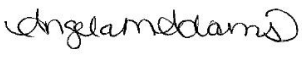
This **policy** is governed by applicable federal law and the laws of California.

Right to examine this policy
You have 10 days after You receive this policy to read and review it. During that 10-day period, if You decide You do not want this policy, You may return it to Us at Our Home Office or to the agent who sold it to You. As soon as it is returned, this policy will be void from the beginning. Premium paid will be returned to You.

THIS IS A LIMITED POLICY WHICH PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENTS ONLY. IT DOES NOT PAY BENEFITS FOR LOSS CAUSED BY SICKNESS.

PLEASE READ THIS POLICY CAREFULLY
NON-PARTICIPATING

This **Policy** is executed for the Company by its President and Secretary:



Andrew M. DiGiorgio, President

Angela Adams, Secretary

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Policyholder Questions or Comments

If You have questions about the coverage under this **policy**, or if You wish to discuss it, You may contact Us at:

Wellfleet Insurance Company
c/o Wellfleet Group, LLC dba Wellfleet Administrators, LLC
PO Box 15369
Springfield, MA 01115-5369
(877) 657-5039

Please have Your **policy** number available when You contact Us. It is on the front page of this **policy**.

Underwritten by Wellfleet Insurance Company
Administrator: Wellfleet Group, LLC dba Wellfleet Administrators, LLC
PO Box 15369
Springfield, MA 01115-5369

Definitions

You will see some words in bold type in this **policy**. The bold type means that We have defined those words in this **policy**. The definitions are in this section. You can find a complete list in the Definitions section of the certificate of coverage.

Covered activity

An activity or event that:

- Takes place under one of the conditions of coverage specified in the conditions of coverage section of the certificate*;* and
- Is sponsored, organized, scheduled or otherwise provided by the **policyholder**

Covered person

A person for whom all of the following applies:

- The person is eligible for coverage as defined in the certificate of coverage.
- The person's coverage has not ended.

The activity or event must be under sole direct supervision of qualified **policyholder** authorities and may, if specified in the **certificate**, include **policyholder** sponsored and supervised travel to and from such an activity or event.

Dates:

Effective date

The date coverage begins as listed on the front page of this **policy**.

Premium due date

Premium is due on the **premium due date** immediately following the date We invoice You.

Termination date

The date coverage ends according to the *Termination* section.

Policy term: The period of time from the **policy effective date** to the **policy termination date** as shown on the cover page of this **policy**.

Policyholder

The **policyholde**r named on the front page of this **policy** for the purpose of coverage under this **policy**.

Premium

The amount the **policyholder** is required to pay to Us to continue coverage.

Policy

This Blanket Accident Only Insurance **Policy** (**policy**). This **policy** consists of several documents taken together.

Premium

Premium - rates

Premium rates are expressed in, and **premiums** are payable in, United States currency. The **premiums** for this **policy** will be based on the rates, the plan and amounts of insurance in effect for **Covered Persons** and the **premium** mode selected as agreed to by the **policyholder** and Us.

Premium Payment

The total **premium** paid by the **policyholder** is the sum of **premiums** for all **Covered Persons**, unless the **policyholder** and **We** agree to another mode of **premium** payment. **Premiums** are paid at **Our** home office or to **Our** authorized agent.

If any **premium** is not paid when due, this **policy** will be cancelled as of the **Premium Due Date** of the unpaid **premium**, except as provided in any applicable **policy** Grace Period section.

Grace Period

A **policy** Grace Period of 31 days will be granted for payment of required **premiums** due after the first **premium**, unless:

1. **We** do not intend to renew this **policy** beyond the period for which **premium** has been accepted; and
2. written notice of **Our** intention not to renew is delivered to the **policyholder** at least 45 days before the **premium** is due.

This **policy** will be in force during the **policy** Grace Period. If the required **premiums** are not paid during the **policy** Grace Period, insurance will end on the last day of the Grace Period. The **policyholder** is liable to **Us** for any unpaid **premium** for the time this **policy** was in force.

Premium Rate Changes

We may change **premium** rates at the end of any **policy term** with at least 31 days advance notice mailed to the last known address of the **policyholder**. We will not increase **premium** rates more frequently than annually, unless one of the events described below occurs.

We may change the **premium** rate during a **policy term** if any one of the following occurs:

1. The terms of this **policy** change;
2. A change in any federal or state law or regulation is enacted, adopted or amended to the extent it affects **Our** benefit obligations under this **policy**.

Any increase or decrease in rate will take effect on the date of the applicable change specified above, subject to required notification. A pro rata adjustment will apply from the date of the change to the end of any period for which **premium** has been paid.

Refund of Premium

We will refund any **premium** minus claims paid for coverage of a specified **covered activity** if:

1. That **covered activity** is cancelled; and
2. The **policyholder** notifies **Us** in writing at least 7 days before the **covered activity** was scheduled to take place.

No insurance will be in effect for any **Covered Person** while they participate in, travel to, attend or otherwise is involved in the cancelled **covered activity**. If this **policy** was issued to insure only the **covered activity** that was cancelled and **We** were notified as required in 2. above, this **policy** will be void from its inception.

Premium – Eligibility Corrections

Premium will always be determined based upon the **effective date** and **termination dates** of a **covered person**.

Final rates

The current **premium** rates and **effective date** for all of the coverages provided under this **policy** are on record with **Us** and You.

Termination

Automatic Termination

This **policy** and all coverage end as of the last day of the grace period if You have not paid Us all **premiums** as of the end of the grace period.

Termination by You

You may end coverage under this **policy** at any time by written notice delivered or mailed to **Us**, effective on receipt or on such later date as specified in the notice. Your termination notice may apply to all classes or any class of **Covered Persons** covered under this **policy**. You can send Us a termination notice during a period for which You have paid **premium**, but Your **termination date** must be after that period.

Termination by Us

We may end this **policy** and all or any coverage it provides:

- Immediately upon written notice to You if You perform any act or practice that constitutes fraud or if You make any intentional misrepresentation of a material fact relevant to the coverage.
- At any time if We give You 31 days advance written notice .

Effect of Termination

You and We continue to be responsible following termination for the duties You and We each incurred prior to the termination of this **policy**. One of Your duties includes payment of **premium** due for coverage through any grace period up to the day of termination. You and We also continue to be responsible for Your and Our duties that this **policy** states are to occur following termination.

You and We have the rights and duties following termination of this **policy**, as stated specifically in this **policy**.

You shall notify **Covered Persons** of the termination of this **policy**. Your notice will comply with applicable federal and state laws. We have the right to notify **Covered Persons** of termination of this **policy**.

Notices – termination of coverage

You shall notify **Covered Persons** in writing, of their rights when coverage stops.

Reinstatement

This **policy** may be reinstated if it lapsed for nonpayment of **premium**. Requirements for reinstatement are written application of the **policyholder** and payment of all overdue **premiums**. Any **premium** accepted in connection with a reinstatement will be applied to a period for which **premium** was not previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Administration Provisions

Indemnification

We agree to indemnify and hold You harmless against that portion of Your liability to third parties as determined by either state or federal regulatory agencies, boards, or other government bodies or by arbitration caused directly by Our willful misconduct, criminal conduct or material breach of this **policy**.

You agree to indemnify and hold Us harmless against that portion of Our liability to third parties as determined by a court of final jurisdiction or by arbitration caused directly by Your negligence, breach of this **policy**, breach of applicable federal and state laws, willful misconduct, criminal conduct, or fraud.

These indemnification obligations end with this **policy**, except as to any matter concerning a claim that has been made in writing within 365 days after termination.

Certificates

The **company** will provide a certificate of insurance for delivery to the **Covered Person.** Each certificate will set forth a statement as to the insurance coverage to which the **Covered Person** is entitled, and to whom the insurance benefits are payable.

Distribution – certificate of coverage and other materials

The **company** or **policyholder** will distribute to You as required by applicable federal and state laws, the certificate and other materials relating to enrollment and coverage features.

General provisions

Applicable law

Applicable law means all federal and state laws that apply to the matters covered by this **policy**. Federal and state laws mean statutes, regulations, official agency direction and guidance, and judicial decisions and orders, as they may be passed or issued, or as they may be amended, from time to time.

Conformity with law

Any provision in this **policy** that is in conflict with the requirements of any state or federal law that apply to this **policy** are automatically changed to conform to the minimum requirements of such laws.

Entire Contract

This **policy** consists of several documents taken together. These documents are:

- Your application
- This **policy**
- The certificate, if applicable
- Any riders, endorsement, inserts, attachments, and amendments to this **policy** or the certificate.

These documents are the entire contract between Us and You.

All certificate documents that are part of the complete **policy** are on file with Us and You.

Changes to the Policy

This **policy**, including the application, endorsements, amendments and any attached papers constitutes the entire contract of insurance. No change in this **policy** will be valid until approved by one of **Our** executive officers and endorsed on or attached to this **policy**. No agent has authority to change this **policy** or to waive any of its provisions. The **company** may agree with the **policyholder** to modify a plan of benefits without the **Covered Person's** consent

Legal Actions

No action at law or in equity will be brought to recover benefits under this **policy** less than 60 days after written proof of loss has been furnished as required by this **policy**. No such action will be brought more than 3 years after the time such written proof of loss must be furnished.

Assignment and delegation

You shall not assign any right or delegate any duty under this **policy** unless We approve it in writing in advance, in conjunction with state law.

We may delegate some of Our functions under this **policy** to third parties. We may also change or end these delegations. We do not need to give You advance notice to enter into, change or end these arrangements, and We do not need Your consent.

Clerical Error

A person's coverage validly in force will not be affected, nor will a person's coverage validly terminated be continued, due to error or delay in keeping records pertaining to insurance under this **policy**. If such error or delay is found, **We** will adjust the **premium** fairly.

Misstatement of Material Fact

If the **policyholder** has misstated any material fact, all amounts payable under this **policy** will be such as the **premium** paid would have purchased had such fact been correctly stated.

Noncompliance with Policy Requirements

Any express or implied waiver by the **company** of any requirements of this **policy** is not a continuing waiver of such requirements. Any failure by the **company** to enforce any **policy** provision will not be a waiver or amendment of that provision.

Discrimination prohibited

You shall not encourage or discourage enrollment in the coverage provided by this **policy** based on health status or health risk.

You shall act so as not to discriminate unfairly between persons in like situations at the time of the action.

Financial Sanctions Exclusion

If coverage provided by this **policy** violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, We cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a valid written Office of Foreign Assists Control (OFAC) license. For more information, visit http://www.treasury.gov/resource-center/sanctions/pages/default.aspx.

Incontestability

The validity of this **policy** will not be contested after it has been in force for 3 years from the **policy Effective Date**, except for non-payment of **premium** or fraudulent misstatements. **We** reserve the right to contest coverage at any time based upon the **Covered Person's** ineligibility for coverage under this **policy** or upon other provisions of this **policy**.

Records

The **policyholder** or its authorized administrator will maintain the records of the **Covered Person's** insurance under this **policy**. **We** will be permitted to examine the **policyholder**'s records relating to the insurance under this **policy** at any reasonable time. The **policyholder** is acting as an agent of the **Covered Person** for transactions relating to this insurance. The actions of the **policyholder** will not be considered **Our** actions.

Reporting Requirements

The **policyholder** or its authorized agent must report all of the following to **Us** by the **premium due date**:

1. the names of all persons insured on this **policy Effective Date**;
2. the names of all persons who are insured after the **policy Effective Date**;
3. the names of those persons whose insurance has terminated;
4. additional information required by **Us**.

We, at **Our** option, may waive reporting of any information specified above.

Non-Participating

This **policy** is non-participating. It does not share in the **Company's** profits or surplus earnings.

Notices

This **policy** requires or permits You and Us to send notices to each other. These notices shall be in writing.

Notice may be delivered:

- In person, and is effective upon delivery
- By United States mail, sent first class, postage prepaid, and is effective three U.S. Postal Service delivery days following the date of mailing
- By commercial carriers UPS and FedEx, effective upon delivery
- By e-mail, facsimile or other electronic means, effective upon sending

Notice sent to Us by mail and commercial carrier shall be sent to:

Wellfleet Insurance Company
c/o Wellfleet Group, LLC dba Wellfleet Administrators, LLC
PO Box 15369
Springfield, MA 01115-5369

Notice sent to You by mail and commercial carrier shall be sent to the address that We have on file for You or Your agent.

You and We must designate specific e-mail addresses, facsimile numbers or other electronic means in writing for purpose of notices.

Privacy

We will protect the personal health information of **Covered Persons** as required by federal and state laws. We will use it and share it with others as needed for their care and treatment. We will also use and share it to help Us process **provider's** claims and otherwise help Us administer this **policy**. For a copy of Our Notice of Privacy Practices, call the toll-free number on the back of the ID card or log on to www.wellfleetinsurance.com.

Third Parties Rights

This **policy** does not give any rights or impose any duties on third parties except as specifically stated.

Workers' Compensation Insurance

This **policy** is not in place of and does not affect any requirements for coverage under any Workers' Compensation law.

THE REMAINDER OF THIS CONTRACT CONSISTS OF THE CERTIFICATE, APPLICATION, RIDERS AND AMENDMENTS, IF ANY, THAT ARE ATTACHED TO, AND MADE A PART OF THIS POLICY.

WELLFLEET INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

BLANKET ACCIDENT INSURANCE CERTIFICATE

POLICYHOLDER:	San Bernardino CCD (San Bernardino Valley, Crafton Hills)
POLICY NUMBER:	WI2526CAACC102
POLICY EFFECTIVE DATE:	August 1, 2025
POLICY TERM:	August 1, 2025 through July 31, 2026
STATE OF ISSUE:	California
POLICY ANNIVERSARY:	August 1, 2026

The **certificate** is a legal contract between the Policyholder and Wellfleet Insurance Company (herein referenced as "**We, Us, Our** and **Company**").

This **certificate** contains the terms under which the Insurance Company agrees to insure certain persons and pay benefits.

F

The **certificate** and the coverage provided by it become effective at 12:00 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 **certificate**.

The **certificate** and the coverage provided by it terminates at 11:59 P.M. at the address of the **policyholder**. The following pages form a part of this **certificate** as fully as if the signatures below were on each page.

10 DAY RIGHT TO RETURN THIS CERTIFICATE - If for any reason, the covered person is not satisfied with this certificate, he or she may return it to us within 10 days after receiving it. Upon its return, we will refund any premium paid and this certificate will be deemed void, just as though it had never been issued.

We and the **policyholder** agree to all the terms of this **certificate**.

THIS IS A LIMITED CERTIFICATE WHICH PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENTS ONLY. IT DOES NOT PAY BENEFITS FOR LOSSES CAUSED BY SICKNESS.

PLEASE READ THIS CERTIFICATE CAREFULLY

NON-PARTICIPATING

SIGNED FOR WELLFLEET INSURANCE COMPANY

Andrew M. DiGiorgio, President

Angela Adams, Secretary

Underwritten by: Wellfleet Insurance Company
5814 Reed Road Fort Wayne, IN 46835

Administrator: Wellfleet Group, LLC dba Wellfleet Administrators, LLC
P.O. Box 15369.
Springfield, MA 01115-5369
877-657-5039

Covered Persons who have complaints regarding their ability to access needed health care in a timely manner may complain to Us and to the California Department of Insurance. Our contact information can be found above and the Consumer Services Division of the Department of Insurance's contact information can be found below.

California Department of Insurance
300 S. Spring Street
11th Floor
Los Angeles, CA 90013
Inside State Toll-Free: 1-800-927-4357
Outside State: 1-213-897-8921
Fax: 1-213-897-9641
TDD: 1-800-482-4833
www.insurance.ca.gov

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SCHEDULE OF BENEFITS

The benefits provided by this certificate will be paid, subject to applicable conditions, limitations and exclusions, under the following coverages to protect against hazards that may occur during specific activities, situations or events.

The *Schedule of Benefits* provides a brief outline of the coverage and benefits provided by this certificate. Please read the conditions of coverage section and each benefit description section for full details.

COVERED PERSONS:

Eligible Class(es) of Covered Persons	**Description of Class**
Class 1	**ICS-** All student athletes, student trainers, student managers and student coaches while participating in or attending any regularly scheduled practice or competition supervised by an authorized representative of the college; or While traveling directly to and from practices or competition with other members as a group, provided such travel is supervised by an authorized representative of the college.
Class 2	**Registered Students-**FT- All degree seeking students, while attending regularly scheduled classes at college; First Responders (if aplictable) or While attending college-sponsored activities, including club activities, or traveling under college supervision to and from college sponsored events.

COVERED ACTIVITIES:

Class 1	**ICS Sports Covered:** **Men's:** Baseball, Basketball, Cross Country, Football, Golf, Tennis, Track & Field, Soccer, Swimming/Diving, Water Polo **Women's:** Basketball, Cross Country, Frack and Field, Sand Volleyball, Softball, Soccer, Swimming/Diving, Volleyball, Water Polo
Class 2	During participation in **policyholder** scheduled and supervised activities**.**

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Principal Sum Amount Class 1 **Principal Sum Amount** Class 2	$10,000 $10,000
Loss must occur within	365 days of the covered accident
Accidental Death and Dismemberment Aggregate Limit	$1,000,000
SCHEDULE OF COVERED LOSSES	
Covered Loss	**Benefit**
Loss of Life	**Principal Sum**
Loss of Both Hands or Both Feet	**Principal Sum**
Loss of One Hand and One Foot	**Principal Sum**
Loss of Sight of Both Eyes	**Principal Sum**
Loss of One Hand or foot and Sight of One Eye	50% of **Principal Sum**
Loss of One Hand or One Foot	50% of **Principal Sum**
Loss of Thumb and Index Finger of the Same Hand	50% of **Principal Sum**
Loss of all Four Fingers of the Same Hand	50% of **Principal Sum**
Loss of all the Toes of the Same Foot	50% of **Principal Sum**
Loss of Thumb	50% of **Principal Sum**
Loss of Sight in One Eye	50% of the **Principal Sum**
Loss of Speech and Hearing (in both ears)	**Principal Sum**
Loss of Hearing (in both ears)	**Principal Sum**
Loss of Speech	50% of the **Principal Sum**
Loss of Hearing in one ear	50% of the **Principal Sum**

ACCIDENT MEDICAL BENEFITS

Any benefit limits for Accident Medical Benefits apply, unless otherwise specified, on a per covered accident basis.

The **covered injury** must result from a **covered accident**.

Covered Expenses for which benefits are payable are outlined below. Unless otherwise indicated, benefits are payable as a percentage of usual and customary charges.

SCOPE OF COVERAGE APPLICABLE TO ACCIDENT MEDICAL BENEFITS Class 1 & Class 2	
Full Excess Accident Medical Maximum **Class 1** **Class 2**	 $25,000 per **covered accident** $50,000 per **covered accident**
Accident Medical benefit amount	100% of **usual and customary charges (U&C)**
Benefit Period - Individual must be covered under this plan at the time of the **accident** causing the loss	52 weeks from the date of the **covered accident**
Treatment window: - First **covered expenses** must be **incurred** within	90 days of the **covered accident**

ACCIDENT MEDICAL BENEFITS

Covered Expenses	Coverage and Other Limits
Inpatient Hospital Services	
Hospital Room & Board Expenses and miscellaneous services and supplies. Subject to semi-private room rate unless intensive care unit is required.	The benefit amount shown above
Skilled Nursing Facility	The benefit amount shown above
Minimum **Inpatient hospital stay** prior to confinement in **skilled nursing facility**.	3 consecutive days per **covered accident**
Maximum Number of **skilled nursing facility** days	120
Outpatient Facilities	
Ambulatory Medical or Surgical Center	The benefit amount shown above
Outpatient Hospital Surgical Services	The benefit amount shown above
Outpatient Hospital Non-Surgical Services	The benefit amount shown above
Emergency Room Expenses	The benefit amount shown above
Home Health Care	The benefit amount shown above
Minimum **Inpatient hospital stay,** including **inpatient hospital stays** in a **skilled nursing** or **rehabilitation facility,** prior to receiving **home health care** services	3 consecutive days
Home health care must begin within	10 consecutive days after the Minimum **Inpatient hospital stay**
Maximum Number of **home health care** visits	120 per **covered accident**
Rehabilitation Facility	The benefit amount shown above
Maximum Number of days	90 per **covered accident**
Physician Services	
Surgeon Expenses	The benefit amount shown above
Assistant Surgeon	The benefit amount shown above
Urgent Care Expenses	The benefit amount shown above
Second Opinion or Consultation	The benefit amount shown above
Physician's Assistant	The benefit amount shown above
Anesthesia and its Administration	The benefit amount shown above
In-Hospital or **Office Visits**	The benefit amount shown above
Office Visits	The benefit amount shown above
Outpatient X-ray, CT Scan, MRI and Laboratory Tests	
Outpatient X-Rays, CT Scans & MRIs and Laboratory Tests	The benefit amount shown above
Outpatient Services and Supplies	
Outpatient Physical Therapy	The benefit amount shown above
Maximum Visits Per Day	1
Outpatient Occupational and Speech Therapy	The benefit amount shown above
Maximum Visits Per Day	1
Nursing Services - Private Duty Nursing	The **benefit** amount shown above
Ambulance Services	The benefit amount shown above
Durable Medical Equipment and Orthopedic Braces and Appliances	The benefit amount shown above
Medical Services and Supplies	The benefit amount shown above

Prosthetic Devices	The benefit amount shown above
Dental Services	The benefit amount shown above
Prescription Drugs	The **benefit** amount shown above
Other Benefits	
Expanded Medical Benefit for Covered Sports Conditions	Same as any other **covered loss**
Covered Sports Conditions	bursitis; sprains; hernia; MRSA; muscle tears; tendonitis; stress fractures; shin splints; injury to joints and surrounding muscle and tissue; tennis elbow; and repetitive motion injuries
Heart and Circulatory Conditions	Same as any other **covered loss**
Covered Heart and Circulatory Conditions	heat exhaustion; heart attack; cardia arrest; stroke; burst aneurysm
Treatment of Hernia	Same as any other **covered loss**
Emergency Illness Expense Benefit	
Emergency Illness Treatment	up to a maximum of $1,000
Re-Aggravation of Prior Injury Benefit	Same as any other **covered loss**

DEFINITIONS

In the **certificate**, certain words have specific meanings. The words defined below and **bold** within the text of this **certificate** have the meanings set forth below.

Accident or Accidental means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place while the **covered person** is covered under this **certificate**.

Accidental Death and Dismemberment Aggregate Limit means the maximum amount payable under this **certificate** if more than one **covered person** suffers a **covered loss** as a result of the same **accident**, and if **Accidental Death and Dismemberment Benefit** amounts are payable for those losses provided by this **certificate.** The maximum amount payable for all such losses for all **covered persons** under the **Accidental Death and Dismemberment Benefit** combined will not exceed the **Accidental Death and Dismemberment Benefit Aggregate Limit** shown in the *Schedule of Benefits*. If the combined maximum amount otherwise payable for all **covered persons** must be reduced to comply with this provision, the reduction will be taken by applying the same percentage of reduction to the individual maximum amount otherwise payable for each **covered person** for all such losses under all the **Accidental Death and Dismemberment** benefits combined.

Aggregate Limit means the maximum amount payable under this **certificate** if more than one **covered person** suffers a **covered loss** as a result of the same **accident.**

Ambulatory Medical or Surgical Center means any licensed public or private establishment which:

1. Has an organized medical staff;
2. Has permanent facilities that are equipped and operated mainly for the purpose of providing medical or **surgical** treatment;
3. Provides continuous services of **physicians** and registered **nurses**, whenever a patient is in the facility; and
4. Does not provide services or other accommodations for patients to stay overnight.

Benefit Period means the period of time from the date of the **covered accident**, as shown in the Schedule of Benefits, **covered expenses** are payable for treatment of a **covered injury**.

Certificate means the **certificate** issued by **us**.

Company or **We, Us, Our** means Wellfleet Insurance Company, domiciled in Fort Wayne Indiana.

Covered Accident means a sudden, unforeseen event that results in a **covered injury** or **covered loss** and meets all of the following conditions:

1. Occurs while the **covered person** is insured under this **certificate**;
2. Occurs under one of the **conditions of coverage** specified in the **conditions of coverage** section of this **certificate***;*
3. Is not otherwise excluded under the terms of this **certificate**.

Covered Activity means an activity or event that:

1. Takes place under one of the **conditions of coverage** specified in the **conditions of coverage** section of this **certificate***;* and
2. Is sponsored, organized, scheduled or otherwise provided by the **policyholder**.

The activity or event must be under sole direct supervision of qualified **policyholder** authorities and may, if specified in this **certificate**, include **policyholder** sponsored and supervised travel to and from such an activity or event.

Covered Expenses means the **usual and customary** charges for services or supplies listed in the *Schedule of Benefits,* and described in the **Accident Medical Benefits** section, that the **covered person incurred** during the **benefit period** for **medically necessary** treatment of a **covered injury**. A **physician** must recommend and approve these services or supplies. A **covered expense** is deemed to be **incurred** on the date treatment, service, or supply that gave rise to the expense or the charge, was rendered or obtained.

Covered Injury means any bodily harm that results from a **covered accident** and occurs while such a person is participating in a **covered activity**. All **covered expenses** incurred as a result of the same or related cause (including any complications) shall be considered as resulting from one **covered injury**. A **covered injury** includes aggravation of an injury sustained before the **covered accident**, if such aggravation resulted from a **covered accident**, but only if a **physician** had released the **covered person** to participate in the **covered activity** during which the **covered accident** occurred.

Covered Loss means a loss:

1. Which is the result of a **covered injury** to the **covered person**;
2. For which benefits are payable under this **certificate**; and
3. Which is not otherwise excluded under the terms of this **certificate**.

Covered Person means a person who is eligible for coverage as identified in the *Schedule of Benefits* for whom proper premium payment has been made, and who is insured under this **certificate**.

Durable Medical Equipment means a device which:

1. Is primarily and customarily used for medical purposes, is specially equipped with features and functions

that are generally not required in the absence of **sickness** or **covered injury** and is able to withstand repeated use;
2. Is used exclusively by the **covered person**;
3. Is routinely used in a **hospital** but can be used effectively in a non-medical facility;
4. Can be expected to make a meaningful contribution to treating the **covered person's covered injury**; and
5. Is prescribed by a **physician** and the device is **medically necessary** for rehabilitation.

Durable Medical Equipment does not include:
1. Comfort and convenience items;
2. Equipment that can be used by **immediate family members** other than the **covered person**;
3. Health exercise equipment; and
4. Equipment that may increase the value of the **covered person's** residence.

Emergency Illness means a sudden and unexpected medical condition, with no known mechanism of injury. The illness must be so acute that a prudent layperson who possesses an average knowledge of health and medicine believes it would result in serious impairment to body function or may place the life of the **covered person** in jeopardy if not treated as soon as possible.

Heart or Circulatory Malfunction means disease or illness of the heart or circulatory system for which: (1) the symptom(s) of such malfunction(s) is (are) first medically treated while this **certificate** is in force with respect to such **covered person** and within 72 hours after participation in a **covered activity**, and (2) such **covered person** has not, prior to the date of such participation in the **covered activity**, been diagnosed with, or received any medication for any myocardial infarction, angina pectoris, coronary thrombosis or a cerebral vascular incident; and before such participation the **covered person** has not been medically advised of or received any medical treatment for such disease or illness.

HMO – Health Maintenance Organization means any organized system of health care that provides health maintenance and treatment services for a fixed sum of money agreed and paid in advance to the provider of service.

Home means the structure or land on which the **covered person** permanently resides.

Home Health Care Agency means an agency that:
1. Is constituted, licensed and operated under the provision of Title XVIII of the Federal Social Security Act, or qualified to be so operated if application was made, and certified by the jurisdiction in which they are established; and
2. Is engaged primarily in providing therapeutic services in the **covered person's** home under the supervision of a **physician** or a **nurse**; and
3. Maintains clinical records on all patients.

Home Health Aide is a person who is not an **immediate family member** or anyone who lives with the **covered person** and:
1. Provides care of a medical or therapeutic nature; and
2. Reports to and is under the direct supervision of a **home health care agency**.

Hospital means an institution that meets all of the following:
1. It is licensed as a **hospital** pursuant to applicable law;
2. It is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;

3. It is managed under the supervision of a staff of medical doctors;
4. It provides 24-hour nursing services by or under the supervision of a graduate registered **nurse** (R.N.);
5. It has medical, diagnostic and treatment facilities, with major **surgical** facilities on its premises, or available on a prearranged basis;
6. It charges for its services.

The term **hospital** does not include a clinic, facility, or unit of a **hospital** for:
1. Rehabilitation, convalescent, custodial, educational or nursing care;
2. The aged, drug addicts or alcoholics;
3. A Veteran's Administration **hospital** or Federal Government **hospital**s unless the **covered person incurs** an expense and there is a legal obligation to pay.

Hospital Stay means a confinement in a **hospital**, ordered by a **physician**, over one or more nights when room and board and general nursing care are provided at a per diem charge made by the **hospital**. The **hospital stay** must result from a **covered accident**. Separate **hospital stays** due to the same **covered accident** will be treated as one **hospital stay** unless separated by at least 90 days.

Immediate Family Member means a person who is related to the **covered person** in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent, including stepparent, brother or sister, including stepbrother or stepsister, or child, including legally adopted child or stepchild.

Incurred or Incurs means an obligation to pay for a **covered expense** for treatment, service or purchase of supplies, deemed to be the date it is provided to the **covered person**.

Inpatient means if the **covered person** is confined for at least one full day's **hospital** room and board. The requirement that the **covered person** be charged for room and board does not apply to confinement in a Veteran's Administration **hospital** or Federal Government **hospital** and in such case, the term "**inpatient**" shall mean that the **covered person** is required to be confined for a period of at least a full day as determined by the **hospital**.

Intercollegiate Sport means a sport which:
1. Has been accorded varsity or junior varsity status by the participating college or university; and
2. Is administered by such college or university's department of **intercollegiate** athletics for which the eligibility of the participating student athlete is reviewed and certified in accordance with the applicable **intercollegiate sport**s organization's legislation, rules or regulations; and
3. Entitles qualified participants to receive the participating college or university's official awards.

Medically Necessary/Medical Necessity means care, services or supplies provided to the **covered person**, solely by or at the direction of a treating **physician** exercising prudent medical judgment and acting independently of **us**, for the purpose of evaluating, diagnosing or treating a **covered injury** sustained as the result of a **covered accident**, that are:
1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration;
3. Considered effective for the **covered injury**; and
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of a **covered injury**.

For the purposes of this definition, *Generally Accepted Standards of Medical Practice* means:

a. Standards that are based on credible scientific evidence published in peer-reviewed, medical literature generally recognized by the relevant medical community;
b. **Physician** and health care provider specialty society documents;
c. The views of **physicians** and health care providers practicing in the relevant clinical areas; and
d. Any other relevant factors.

Non-Preferred Provider means any **hospital**, **physician**, or other provider of health care services which is not a member of an **HMO** or **PPO** plan.

Nurse means a licensed graduate registered **nurse** (R.N.) or a licensed practical **nurse** (L.P.N.) who is not:

1. The **covered person**;
2. The **covered person's immediate family member** or the **covered person's** spouse;
3. A person living in the **covered person's** household; or
4. A person employed or retained by the **policyholder**.

Outpatient means the **covered person** receives **medically necessary** services and supplies while not an **inpatient** in a **hospital**.

Other Health Care Plan means any arrangement, whether individually purchased or incident to employment or membership in an association or other group, which provides benefits or services for health care, dental care or disability benefits. A **health care plan** includes group, blanket, franchise, family or individual:

1. Insurance policies;
2. Subscriber contracts;
3. Uninsured or self-funded agreements or arrangements;
4. Coverage provided through **Health Maintenance Organizations (HMO)**, **Preferred Provider Organizations (PPO)** and other prepayment, group practice and individual practice plans;
5. Medical benefits provided under automobile "fault" and "no-fault" type contracts;
6. Medical benefits provided by any governmental plan or coverage or other benefit law, except:
   a. A state-sponsored Medicaid plan; or
   b. A plan or law providing benefits only in excess of any private or non-governmental plan;
7. Other valid and collectible medical or health care benefits or services.

Policyholder means the entity, named on this **certificate's** face page, to which the **company** issues this **certificate**.

Policy Term means the time period defined for the **policyholder** shown on the cover page of this **certificate**.

PPO – Preferred Provider Organization means an organization offering health care services through designated health care providers who agree to perform these services at rates lower than **Non-Preferred Providers**.

Pre-existing Condition means a disease or physical condition for which the **covered person** received medical advice or treatment from a **physician** within the 12-month period before the **covered person's** coverage became effective under the **policy**.

Principal Sum Maximum Amount means the amount payable for each **covered person** within a plan year as shown in the *Schedule of Benefits.*

Rehabilitation Facility means a legally operating institution or part of an institution which has a transfer agreement with one or more **hospital**s and which:

1. Is primarily engaged in providing comprehensive multi-disciplinary physical rehabilitative services or rehabilitation **inpatient** care; and
2. Is duly licensed by the appropriate government agency to provide such services; and
3. Is required to be accredited by the Joint Commission on Accreditation of Health Care Organizations or the Commission on Accreditation of Rehabilitation Facilities.

A **rehabilitation facility** does not include institutions which provide only minimal care, custodial care, care for the terminally ill, part-time care, or services or facilities for drug abuse or alcoholism.

School means the participating **school** where the **covered person** is enrolled or employed. The **school** must be licensed or accredited, as applicable, by the jurisdiction where it is located, to provide the care, education or training for which the **covered person** is enrolled.

Sickness means a physical or mental illness, including pregnancy.

Sojourn or Personal Deviation means (1) non-business travel or activities undertaken while traveling to and from an activity which is covered under this **certificate**; and (2) unrelated to the **covered activity**; and (3) not incidental to the purpose of the **covered activity**; and (4) non-business travel or activities that coincide with the **covered person's covered activity.**

Surgical Procedure means:

1. A cutting procedure;
2. Suturing a wound;
3. Treatment of a fracture;
4. Reduction of a dislocation;
5. Electrocauterization;
6. Diagnostic and therapeutic endoscopic procedures; and
7. An operation by means of laser beam.

Usual and Customary Charge is the amount of a provider's charge that is eligible for coverage. The **covered person** is responsible for all amounts above what is eligible for coverage.

The **usual and customary charge** depends on the geographic area where the **covered person** receives the service or supply. The table below shows the method for calculating the **usual and customary charge** for specific services or supplies:

Service or Supply	**usual and customary charge**
Professional services and other services or supplies not mentioned below	The Reasonable Amount Rate
Services of **hospitals** and other facilities	The Reasonable Amount Rate

Special terms used

- Geographic area is normally based on the first 3 digits of the U.S. Postal Service zip codes. If **we** determine **we** need more data for a particular service or supply, **we** may base rates on a wider geographic area such as an entire state.

- "Reasonable amount rate" means the **covered person's** plan has established a reasonable rate amount as follows:

Service or Supply	Reasonable Amount Rate
Professional services and **inpatient** and **outpatient** charges of **hospitals**	The lesser of: 1. The billed charge for the services. 2. An amount determined using current publicly-available data which is usual and customary when compared with the charges made for a) similar services and supplies and b) to persons having similar medical conditions in the geographic area where service is rendered. 3 An amount based on information provided by a third party vendor, which may reflect 1 or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable providers' fees and costs to deliver care.

Our reimbursement policies:
We reserve the right to apply **our** reimbursement policies to all services including involuntary services. **Our** reimbursement policies may affect the **usual and customary charge**. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the provider

Our reimbursement policies are based on **our** review of:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of **physicians** and dentists practicing in the relevant clinical areas

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

No payment will be made under this **certificate** for any expenses incurred which, in **our** judgment, are in excess of **usual and customary charges**.

War means a state or period of declared or undeclared **war** whether civil or international, any substantial armed conflict with organized forces of a military nature between nations, states or parties.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Policy Effective Date
We agree to provide **Accident** Insurance Benefits described in this **certificate** in consideration of the **policyholder**'s application and payment of the Initial Premium when due. Insurance begins on the **policy** Effective Date shown on this **certificate's** first page.

Eligibility
A person is eligible for insurance under this **certificate** when they meet the definition of a **covered person** shown in the *Schedule of Benefits*. A **covered person** may be insured under only one Covered Class, even though they may be eligible under more than one Covered Class.

Effective Date for Individuals
Insurance becomes effective for the **covered person** on the latest of the following dates:

1. The **policy** Effective Date; or
2. The date the person becomes a member of an eligible class of persons as described in the Description of Class section of the Schedule of Benefits.

In no instance will insurance for the **covered person** become effective before the **policy** Effective Date. Coverage is in effect for each **covered person** when participating in a **covered activity**.

TERMINATION OF INSURANCE
Insurance for the **covered person** will end on the earliest of:

1. The date the **covered person** is no longer in an Eligible Class; or
2. The end of the period for which the last premium is made; or

Termination does not affect a claim for a **covered loss** due to a **covered accident** that occurs before the termination date. However, in no instance will benefits extend beyond the earliest or earlier of:

1. The end of the **Benefit Period**; or
2. The date benefits equal to any applicable Benefit Limit, as shown in the *Schedule of Benefits*, have been paid.

GENERAL EXCLUSIONS

In addition to any benefit-specific exclusion, benefits will not be paid for any **covered injury**, **covered loss** or **covered expense** which directly results from any of the following unless coverage is specifically provided for by name in this **certificate**:

1. Any service, treatment or supply that is not considered **medically necessary** as defined in this **certificate.**
2. Expenses **incurred** after the end of the **Benefit Period**, even if **incurred** for continuing services or treatment of a **covered injury**.
3. Benefits provided by a Government plan (except Medicaid and other public assistance plans).
4. Injuries compensable under Workers' Compensation law or any similar law.
5. **Sojourns or Personal deviations**
6. Declared or undeclared **war** or act of **war**.
7. Commission of or attempt to commit a felony or an assault by the person whose **covered injury** or **sickness** is the basis of claim, or to which a contributing cause was such person's being engaged in an illegal occupation.
8. Commission of or active participation in a riot or insurrection.

9. Practice or play in any sports activity, including travel to and from the activity and practice except as specifically listed in the Schedule of Benefits.
10. Flight in, boarding or alighting from an aircraft, except as a fare-paying passenger on a regularly scheduled commercial airline.
11. Travel in or on any on-road and off-road motorized vehicle that does not require licensing as a motor vehicle.
12. An **accident** if the **covered person** is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless: (a) The **covered person** holds a valid learner's permit and (b) The **covered person** is receiving instruction from a Driver's Education Instructor.
13. **Sickness**, disease, bodily or mental infirmity, bacterial or viral infection or medical or **surgical** treatment thereof, except for any bacterial infection resulting from an **accidental** external cut or wound or **accidental** ingestion of contaminated food.
14. **Medical** or **surgical** treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice unless it occurs during treatment of injuries sustained in a **covered accident**.
15. Travel outside the United States and the territories and possessions of the United States.
16. **Voluntary** ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a **physician** and taken in accordance with the prescribed dosage.
17. An **accident** that occurs while on active duty service in the military, naval or air force of any country or international organization. Upon **Our** receipt of proof of service, **we** will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days.
18. Treatment in any Veteran's Administration, Federal, or state facility, unless there is a legal obligation to pay.
19. Examination or prescriptions for, or purchase, repair or replacement of, eyeglasses, contact lenses.
20. Hearing aids, or purchase, repair or replacement of.
21. Wheelchairs, braces, appliances, orthopedic braces, or orthotic devices except due to a covered accident as described elsewhere in this certificate.
22. Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the **covered person** has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the **covered accident** occurred.
23. Rest cures, long-term care or custodial care.
24. Cosmetic surgery or care, or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to:
    a. Cosmetic surgery resulting from a **covered accident**, if the **covered person's** initial treatment had begun within 12 months of the date of the **covered accident**;
    b. Reconstruction incidental to or following surgery resulting from a **covered accident**;
    c. Any unplanned and unintended adverse consequences that may result during the treatment of a **covered accident**.
25. Any elective or routine treatment, surgery, health treatment, or examination, including any service, treatment or supplies that: (a) Are deemed to be experimental or investigational; and (b) Are not recognized and generally accepted medical practice in the United States.
26. Services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay.
27. Repair or replacement of existing dentures, partial dentures, braces or bridgework, unless damaged or destroyed in a **covered accident**.
28. Treatment or services provided by the **covered person's immediate family**.

29. Personal services, or comfort/convenience items such as television and telephone or transportation.
30. Orthopedic appliances used mainly to protect an injury.
31. Expenses payable by any automobile insurance **policy** without regard to fault.
32. Services or treatment provided by an infirmary operated by the **policyholder.**
33. Treatment or service provided by a private duty **nurse** except due to a **covered accident** as described elsewhere in this **certificate**.
34. Charges for hot or cold packs for personal use.
35. Custodial Care service and supplies.
36. Expenses that are not recommended and approved by a **physician**.
37. Repair or replacement of existing artificial limbs, eyes and larynx, unless damaged or destroyed in a **covered accident**.
38. Treatment of an injury resulting from or contributed to by frostbite, fainting or seizures.
39. Any expenses in excess of **usual and customary charges** except as provided in this **certificate**.
40. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
41. Non-physical, occupational, speech therapies (art, dance, etc.).
42. Modifications made to dwellings.
43. General fitness, exercise programs.
44. Hypnosis.
45. Rolfing.
46. Biofeedback.

BENEFIT SPECIFIC EXCLUSIONS

In addition to any general exclusions, benefits will not be paid for any **covered injury**, **covered loss** or **covered expense** which directly results from any of the following unless coverage is specifically provided for by name in this **certificate**:

Heart and Circulatory Conditions

Exclusions: The benefits will not be payable if, in the 12 months immediately preceding the **covered accident**, the **covered person** was medically diagnosed as having, or received treatment for:

1. A **heart or circulatory malfunction**; or
2. Hypertension, angina or other heart or circulatory condition.

CONDITIONS OF COVERAGE

Scope of Coverage

This section describes the Scope of **Accident** Coverage under which benefits provided by this **certificate** become payable. Any benefits are payable only once, even though more than one Scope of **Accident** Coverage may apply. Please read these and the General Exclusions and Limitations sections in order to understand all of the terms, conditions and limitations of coverage.

We will pay benefits provided by this **certificate**, subject to all applicable conditions and exclusions, when the **covered person** suffers a loss or incurs **covered expenses** resulting from a **covered accident** that occurs while participating in a **policyholder sponsored, sanctioned and/or supervised covered activity**

We will pay benefits if the **covered person** suffers a **covered injury** from a **covered accident** that occurs while the **covered person** is attending or participating in a **covered activity**.

The **covered person** must be:

1. On the location or premises of the **policyholder**:
   a. During its normal hours;
   b. During scheduled functions; and
   d. During other periods while the **covered person** is participating in a **sponsored, sanctioned and/or supervised activity** of the **policyholder**.
2. Attending or participating in a **sponsored, sanctioned and/or supervised activity** of the **policyholder** while away from the **policyholder** location or premises.
3. Traveling directly, without interruption:
   a. Between the **covered person's home** and the **policyholder** location or premises or the location of a **sponsored, sanctioned and/or supervised activity**; and/or
   b. Between the site of the **sponsored, sanctioned and/or supervised activity** and the **covered person's home** or to the location or premises of the **covered activity**, if the **sponsored, sanctioned and/or supervised activity** is located within or outside the town where the **policyholder** is located including travel while participating in a **covered activity** that requires an overnight stay a stay of one or more nights, or while on a **sojourn or personal deviation**; and/or
   c. While on a **sponsored, sanctioned and/or supervised activity**, if the **sponsored, sanctioned and/or supervised activity** is located the United States and the territories and possessions of the United States including travel while participating in a **covered activity** that requires; and/or
   d. In a vehicle which is:
      i. Designated or furnished by the **policyholder**;
      ii. Operated by a properly licensed adult driver; or
      iii. Under the direct supervision of the **policyholder**.

Definitions for the purposes of this coverage:

Sponsored, Sanctioned and/or Supervised Activity means a **policyholder** authorized function or event:

1. In which the **covered person** participates; and
3. Is organized and approved by the **policyholder**; and
5. Is within the scope of the activities provided by the **policyholder**.

Sponsored, Sanctioned and/or Supervised Activity does not include participating in any activity, including tryouts, practice or any competitions or games for any activity not specifically shown in the *Schedule of Benefits*.

DESCRIPTION OF BENEFITS

This Description of Benefits section describes the benefits provided by this **certificate**. **Any benefits are payable only once, even though more than one covered condition may apply. The covered injury must result from a covered accident.** Benefit amounts, **benefit periods** and any applicable aggregate and benefit-specific maximums are shown in the *Schedule of Benefits*. Please read these and the *General Exclusion Sections* in order to understand all of the terms, conditions and limitations of coverage.

Accidental Death or Dismemberment Benefits

Covered Losses
We will pay the benefit for any one of the **covered losses** listed in the *Schedule of Benefits,* if the **covered person** suffers a **covered loss** resulting from a **covered accident** within the applicable time period specified in the *Schedule of Benefits*.

If the **covered person** sustains more than one **covered loss** as a result of the same **covered accident**, the total of benefits **we** will pay will not exceed the **Principal Sum Amount**.

If a **covered accident** causes the **covered person's** death, the total of all benefits **we** will pay for Accidental Death and any other **covered losses** will not exceed the **Principal Sum Amount**.

Definitions:

Loss of a Hand or Foot means complete **severance** through or above the wrist or ankle joint.

Loss of a Thumb and Index Finger of the Same Hand or Loss of Four Fingers of the Same Hand means complete **severance** through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).

Loss of Hearing means total and permanent loss of ability to hear any sound in one or both ears which is irrecoverable by natural, **surgical** or artificial means.

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

Loss of Speech means total and permanent loss of audible communication which is irrecoverable by natural, **surgical** or artificial means.

Loss of Toes means complete **severance** through the metatarsal phalangeal joint.

ACCIDENT MEDICAL EXPENSE BENEFITS

This Section describes the Scope of Coverage for which Medical Benefits are payable. Any applicable benefit periods, benefit limits and maximums are shown in the *Schedule of Benefits.* Please read these Accident Medical Expense Benefits, the *General Exclusions and Benefit Specific Exclusion* Sections in order to understand all of the terms, conditions and limitations applicable to these benefits.

The covered injury must result from a covered accident.

Covered expenses are shown in the *Schedule of Benefits.*

We will pay a benefit for **medically necessary covered expenses incurred** by the **covered person**, for a **covered injury** that resulted from a **covered accident**.

Benefits will be paid:

1. As long as the first **covered expense** has been **incurred** within the treatment window specified in the *Schedule of Benefits*; and
2. Until any applicable **benefit period** shown in the *Schedule of Benefits* has expired; and
3. Until the total of **covered expenses** paid equals any applicable Benefit Limit or Maximum Limits shown in the *Schedule of Benefits*; and

Full Excess Medical Expense

We will pay **covered expenses**, up to the Full Excess Accident Medical Benefit shown in the *Schedule of Benefits* secondary to any **other health care plan** the **covered person** may have. Benefits payable will be limited to that part of the **covered expense**, if any, which is in excess of the total benefit payable for the same injury under any **other health care plan**:

1. Without regard to any Coordination of Benefits provision in any other health care plan.

If the **other health care plan** also provides benefits on a full excess basis, benefits under this **certificate** will be matched with the **other health care plan** to allow 50% of any **covered expenses** up to the Full Excess Accident Medical Benefit shown in the *schedule of benefits*. Benefits paid under this **certificate** will not exceed:

1. Any applicable maximum; and
2. 100% of the **covered expense** incurred when combined with benefits paid by any **other health care plan**.

For the purposes of this **certificate**, a **covered person's** entitlement to any **other health care plan** will be determined as if this **certificate** did not exist and will not depend on whether timely application for benefits from any **other health care plan** is made by or on behalf of the **covered person**.

Benefits under this **certificate** will be reduced to the extent that benefits for **covered expenses** are covered by any **other health care plan** whether or not a claim is made for such benefits.

Non-Duplication of Benefits

This provision applies if the **covered person**:

1. Is covered by any **other health care plan**; and
2. Would, as a result, receive total medical expense or service benefits in excess of the expenses actually incurred.

In this case, the **covered expenses We** will pay under this **certificate** will be reduced by such excess. This provision does not apply if **We** would be primary under any Coordination of Benefit provision in any **other health care plan**.

Benefits paid under this **certificate** will not exceed:

1. Any applicable maximum; and
2. 100% of the **covered expense** incurred when combined with benefits paid by any **other health care plan**.

Accident Medical Expense Benefits

Covered Expenses

We will pay covered expenses incurred by the covered person for the following medical services and supplies when due to a covered accident. Any applicable coinsurances, benefit deductibles, benefit periods, benefit limits and maximums are shown in the *Schedule of Benefits.*

INPATIENT HOSPITAL SERVICES

Hospital Room and Board Expenses and miscellaneous services and supplies

We will pay **covered expenses incurred** by the **covered person** for:

1. Confinement in a semi-private room, unless an intensive care or coronary care unit is required, for each day of such confinement;
2. Any other confinement, for each day of the **hospital stay;**
3. Miscellaneous expenses charged by a **hospital**. Miscellaneous expenses include, but are not limited to X-rays, CT Scans, MRIs, laboratory tests (including professional fees); in-**hospital physical therapy** (including professional fees); **nurse** services; orthopedic appliances; pre-admission tests; drugs and medicines (excluding take-home drugs); dressings; and all other medically necessary and prescribed **covered expenses** other than room and board, for services received during a **hospital stay**.

OUTPATIENT FACILITIES

Ambulatory Medical or Surgical Center

We will pay **covered expenses incurred** by the **covered person** for medical or **surgical** treatment provided in a licensed facility providing ambulatory medical or **surgical** treatment that is not a **hospital** or **physician**'s office.

Outpatient Hospital Surgical Services

We will pay **covered expenses incurred** by the **covered person** for miscellaneous expenses charged by a **hospital**. Miscellaneous expenses include but are not limited to use of the operating room; X-rays, CT Scans, MRIs, laboratory tests (including professional fees); therapeutic services (excluding **physical therapy**)**;** orthopedic appliances; drugs and medicines (excluding take-home drugs and medicines); and all medically necessary expenses for services received during outpatient surgical treatment.

Outpatient Hospital Non-Surgical Services

We will pay **covered expenses incurred** by the **covered person** for miscellaneous expenses charged by a **hospital**. Miscellaneous expenses include diagnostic X-rays, CT Scans, MRIs, laboratory tests (including professional fees); therapeutic services (excluding **physical therapy**)**;** orthopedic appliances; drugs and medicines (excluding take-home drugs and medicines); and all medically necessary expenses for services received during outpatient treatment in a **hospital**.

Emergency Room Expenses

We will pay **covered expenses incurred** by the **covered person** for **outpatient** emergency room expenses received in a **hospital**. When emergency room treatment is immediately followed by admission to a **hospital**, such treatment will be an Inpatient **hospital covered expense**.

Rehabilitation Facility

We will pay **covered expenses incurred** by the **covered person** for physical and occupational rehabilitation provided to the **covered person** at a **rehabilitation facility**. Treatment must be rendered by a **physician** or provided at a **physician's** direction.

PHYSICIAN SERVICES

We will pay **covered expenses incurred** by the **covered person** for **physician** Services listed below.

Surgeon Expenses

1. **Covered expenses** charged for performing a **surgical procedure**. Two or more **surgical procedures** through the same incision will be considered as one procedure. The **covered person's** surgeon may perform two or more surgical or bilateral procedures on the **covered person** during one operation but in separate operative fields. When this happens, **we** will pay:
   - 100% of the surgery for the primary procedures
   - 50% of the surgery for the secondary procedure
   - 25% if the surgery for each of the other procedures, if any.
2. **Covered expenses** charged for treatment of fractured and dislocated bones, operations that involve cutting or incision and/or suturing of wounds or any other **surgical procedure**, including aftercare, which is given in the **outpatient** department of a **hospital** or an **ambulatory medical or surgical center**.

Assistant Surgeon - **covered expenses** charged by an assistant surgeon assisting a **physician** performing a **surgical procedure.**

Urgent Care Expenses – **covered expenses** charged for an urgent care **physician** to evaluate and treat an urgent condition.

Second Opinion or Consultation – **covered expenses** charged by a **physician** for a second or third surgical opinion or consultation.

Physician's Assistant – **covered expenses** charged by a **physician**'s Assistant for other than pre- or post-operative care, second or third opinion or consultation:

1. For in-**Hospital** visits; and
2. For office visits.

Anesthesia and its Administration – **covered expenses** charged by a **physician** for anesthesia and its administration.

In-Hospital or Office Visits– **covered expenses** charged by a **physician** for other than pre- or post-operative care, second or third opinion or consultation:

1. For in-**Hospital** visits; and
2. For office visits.

OUTPATIENT X-RAYS, CT SCANS, MRI AND LABORATORY TESTS

Outpatient X-Rays, CT Scans, MRIs and Laboratory Tests

We will pay **covered expenses incurred** by the **covered person** for X-rays, except dental X-rays, CT Scans, MRIs and laboratory tests performed on an **outpatient** basis at a **hospital** or other licensed facility.

OUTPATIENT SERVICES AND SUPPLIES

Outpatient Physical Therapy

We will pay **covered expenses incurred** by the **covered person** for **outpatient physical therapy** when administered by a **physician** to treat a **covered injury**. **Physical therapy** includes: (a) Acupuncture; (b) microthermy; (c) chiropractic adjustment; (d) manipulation;(e) diathermy; (f) massage therapy; (g) heat treatment; and (h) ultrasonic treatment.

Outpatient Occupational and Speech Therapy

We will pay **covered expenses incurred** by the **covered person** for **outpatient** occupational and speech **therapy** required for rehabilitative treatment of a **covered injury**.

Nursing Services – Private Duty Nursing

We will pay **covered expenses incurred** by the **covered person** for services other than routine **hospital** care, rendered by a private duty **nurse**.

Ambulance Services

We will pay **covered expenses incurred** by the **covered person** for ground, air or water ambulance service to transport the **covered person** from the place where the **covered accident** occurred to the nearest medically appropriate facility. Air and water will be covered when:

- Professional ground Ambulance transportation is not available
- The **covered person's** condition is unstable, and requires medical supervision and rapid transport
- The **covered person** is traveling from one **hospital** to another and
    - The first **hospital** cannot provide the emergency services the **covered person** needs
    - The two conditions above are met.

Durable Medical Equipment and Orthopedic Braces and Appliances

We will pay **covered expenses incurred** by the **covered person** for rental or, if less, purchase of:

1. A wheelchair or **hospital** bed; or
2. Other medical equipment that has permanent or temporary therapeutic value for the **covered person** and that can only be used by the **covered person**. Permanent or temporary therapeutic value must be certified by the **covered person's** treating **physician**. Examples of items that are not covered include, but are not limited to: computers, motor vehicles and modifications thereof, ramps and installation costs.

Medical Services and Supplies

We will pay **covered expenses incurred** by the **covered person** for:

- Blood and blood transfusions, including processing and administration; and
- Cost and administration of oxygen and other gases.

We will not pay for storage of blood for any reason.

Prosthetic Devices

We will pay **covered expenses incurred** by the **covered person** for initial prosthetic devices, including their fitting, which are required in connection with treatment of a **covered injury**. Prosthetic devices and any benefit limits are shown in the *Schedule of Benefits*. **We** will also pay for repair or replacement of prosthetic devices when damaged in a **covered accident**.

Dental Services

We will pay **covered expenses incurred** by the **covered person** for dental treatment for a **dental injury**, including X-rays, for injury to a tooth:

1. With no fillings or cavities or only fillings or cavities that do not undermine the tooth cusps; and
2. For which pulpal tissues are healthy and intact; and
3. For which periodontal tissue shows little or no signs of active or chronic inflammation. For insurance review purposes, each tooth unit is evaluated under these criteria rather than a blanket rating of the whole mouth.

Covered expenses include examinations, X-rays, restorative treatment, endodontics, oral surgery, initial braces required for treatment of a **covered injury**.

If there is more than one way to treat a dental problem, **we** will pay based on the least expensive procedure if that procedure meets commonly accepted standards of the American Dental Association.

Definitions For purposes of this Benefit:
Dental Injury means an injury or damage to the teeth gingival tissue alveoli or dental prosthesis (while in the mouth of the **covered person** or loss of dental prosthesis while in the mouth of the **covered person**) which is caused solely by a force external to the mouth of the **covered person** while the **covered person** is participating in a **covered activity**.

Dental Treatment means replacement of caps, crowns, dentures, orthodontic appliances including braces, fillings, inlays, crozat appliances, endodontics, oral surgery, examinations and x-ray services required as a result of a **dental injury**.

Exclusions
Benefits will not be payable if:
1. The recommended safety equipment for protection against a **dental Injury** was not worn by the **covered person** while participating in any **covered activity** in which the wearing of such safety equipment is reasonably required;
2. The **dental treatment** is necessitated by:
   a. Sickness, deterioration or disease;
   b. For cosmetic, preventive, diagnostic or orthodontic purposes; or
   c. Any reason other than a **dental injury**.

Prescription Drugs
We will pay the **covered expenses incurred** by the **covered person** for drugs that:
1. Can only be obtained through a **physician**'s written prescription; and
2. Are approved for such prescription use by the Federal Drug Administration (FDA).

We will also pay **covered expenses incurred** for drugs for a **covered injury** that resulted from a **covered accident** that meet 1. above and are prescribed by a **physician** for therapeutic use not specifically approved by the FDA. **We** will not cover prescriptions for non-covered services such as illness or wellness not related to a **covered accident**.

The **covered expense** for a prescription drug is limited to the cost of a generic drug unless substitution of a generic drug is prohibited by law; no generic drug is available; or the **covered person's physician** specifically requests that a non-generic drug be dispensed to the **covered person**.

OTHER BENEFITS

Expanded Medical Benefit for Sports Conditions
We will pay **covered expenses incurred** by the **covered person** for the treatment of the Covered Sports Conditions shown in the *Schedule of Benefits* if they are aggravated by the **covered person's** participation in a **covered activity**.

Heart and Circulatory Conditions

We will pay **covered expenses incurred** by the **covered person** for the treatment of a **heart or circulatory malfunction** if the **heart or circulatory malfunction** occurs and is first manifested during a **covered activity**, subject to the maximum amount shown in the Schedule of Benefits for Covered Heart and Circulatory Conditions.

Exclusions that apply to this coverage are in the *General Exclusions* and *Benefit Specific Exclusions Section*.

Treatment of Hernia

We will pay for **covered expenses incurred** by the **covered person** for the treatment of a hernia, including surgical repair, if the hernia occurs as the result of a **covered injury** sustained by the **covered person** during a **covered activity**.

Emergency Illness Coverage

When the **covered person** is participating in a **covered activity** and experiences sudden onset of an **emergency illness**, **we** will provide:

1. Coverage for temporary stabilization of an **emergency illness** up to the maximum amount shown in the *Schedule of Benefits*.

As described in this benefit: **Emergency Illness** would only be covered for care required to stabilize an **emergency illness** while the **covered person** is away from **home** and engaged in a **covered activity**. Follow-up care beyond initial stabilization of emergency condition would be excluded. Coverage provided by this benefit would be secondary to any benefits provided by any **other health care plan**.

Re-Aggravation of Prior Injury Benefits

We will pay benefits if the **covered person** incurs **covered expenses** during a **covered activity** for re-aggravation of an Injury suffered prior to the effective date of a **covered person's** coverage under this **certificate**.

For the purposes of this Re-aggravation of Prior Injury benefit only, such reaggravation will be considered an "Injury" if the re-injury occurs under circumstances which would have otherwise been covered under this **certificate**. Any exclusion for congenital conditions, sickness, or disease remains in force.

The maximum amount payable under this Re-aggravation of Prior Injury benefit is limited to the amount shown on the Schedule of Benefits.

CLAIM PROVISIONS

Notice of Claim

Written or authorized electronic notice must be given to **us** or **our** agent within 30 days after a **covered accident** occurs or the loss begins or as soon as reasonably possible, but in no case any longer than 90 days after the date of loss. If written or authorized electronic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic notice was given as soon as was reasonably possible. Notice should include the **policyholder's** name and **policy** number and the **covered person's** name and address.

Claim Forms
We send forms for filing proof of loss when **we** receive the notice of claim. If claim forms are not sent within 15 days after **we** receive notice, the proof requirements will be met by submitting, within the time fixed in this **certificate** for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which claim is made. Notice should include the **policyholder's** name and **policy** number and the **covered person's** name and address.

Claimant Cooperation Provision
Failure of a claimant to cooperate with **us** in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Proof of Loss
Written or authorized electronic proof of loss must be given to **us** at **our** office, within 90 days of the loss for which claim is made. If: (a) Benefits are payable as periodic payments; and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which **we** are liable. If written or authorized electronic notice is not given within the time required, no claim will be invalidated or reduced if it is shown that it was not reasonably possible to furnish notice within such time, provided such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than 1 year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity of the claimant.

Time of Payment of Claims
We will pay benefits due under this **certificate** for any loss, other than a loss for which this **certificate** provides any periodic payment, immediately upon receipt of due written or authorized electronic proof of such loss.

Payment of Claims
Except benefits for loss of life, all benefits will be paid to the **covered person**. Upon receipt of due written proof of death, benefits for loss of life will be paid to the **covered person's** named beneficiary in accordance with the Claim Provisions in effect at the time of payment. All other proceeds payable under this **certificate**, unless otherwise stated, will be payable to the **covered person** or to their estate. If any payee of benefits is a minor or otherwise legally incompetent, **we** will pay benefits to the person designated as the legal guardian or conservator. If there is no named beneficiary or surviving beneficiary, the **covered person's** loss of life benefits will be paid in one sum to the first surviving class of following in the order shown below:
(1) The beneficiary named to receive the covered person's proceeds;
(2) Spouse;
(3) Child or children;
(4) Mother or father;
(5) Sisters or brothers; or
(6) The **covered person's** estate.

If the amount of any benefit payable is determined based on benefits payable under another **health care plan**, **we** have the right to require the **covered person** to provide information about that plan and benefits paid or payable for the same claim before **we** pay benefits. **We** may, at **our** option, pay any **accident** medical benefits directly to a health care provider that renders services to the **covered person**, unless the **covered person** requests in writing when submitting the claim that such payment not be made to the provider.

If **we** are to pay benefits to the estate or to a person who is incapable of giving a valid release, **we** may pay $1,000 to a relative by blood or marriage whom **we** believe is equitably entitled.

Any payment made by **us** in good faith pursuant to this provision will fully discharge **us** to the extent of such payment and release **us** from all liability for that payment.

Appeals Procedure
Within 180 days after notice of denial of a claim, the **covered person**, or an authorized representative may appeal any denial of benefits under this **certificate** by sending **us** a written request for review of the denial. **We** will review the information and provide a written response within 30 calendar days of the receipt of the request.

Written request shall be sent to:

Wellfleet Insurance Company
c/o Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369

The **covered person** or an authorized representative may also contact **us** by calling: (877) 657-5039.

Change in Beneficiary: (Applicable only if an Accidental Death or Dismemberment benefit is provided)
The **covered person** can change the beneficiary at any time by giving **us** written notice. The beneficiary's consent is not required for this or any other change which the **covered person** may make unless the designation of beneficiary is irrevocable or otherwise required by law.

Conditional Claim Payment
If the **covered person incurs** expenses for **covered injuries** received in a **covered accident** and it is likely a third party may be liable, **we** will pay benefits if:

1. The **covered person** first agrees in writing to refund the lesser of:
   a. The amount **we** actually paid for such expenses; and
   b. The amount actually received from the third party regardless of whether the amount is for such expenses; and
2. The third party's liability is determined and satisfied whether by settlement, judgment, arbitration or otherwise.

However, if the third party's liability is satisfied in an amount less than the benefits paid under this **certificate**, **we** will pay the difference.

Physical Examination and Autopsy
We, at **our** own expense, have the right and opportunity to examine the **covered person** when and as often as **we** may reasonably require while a claim is pending and to make an autopsy in case of death, where it is not forbidden by law.

Legal Actions
No action at law or in equity will be brought to recover benefits under this **certificate** less than 60 days after written proof of loss has been furnished as required by this **certificate**. No such action will be brought more than 3 years after the time such written proof of loss must be furnished.

Recovery of Overpayment
If benefits are overpaid, **we** have the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this **certificate**.

If there is an overpayment due when the **covered person** dies, **we** may recover the overpayment from the **covered person's** estate.

ADMINISTRATIVE PROVISIONS

Financial Sanctions Exclusion
If coverage provided by this **certificate** violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, **we** cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a county under sanction by the United States, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information, visit https://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Reinstatement
This **certificate** may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are written application of the **policyholder** and payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid, but not to any period more than 60 days prior to the date of reinstatement.

GENERAL PROVISIONS

Certificates
The **company** will provide a **certificate** of insurance for delivery to the **covered person.** Each **certificate** will set forth a statement as to the insurance coverage to which the **covered person** is entitled, and to whom the insurance benefits are payable.

Clerical Error
A **covered person's** coverage validly in force will not be affected, nor will a person's coverage validly terminated be continued, due to error or delay in keeping records pertaining to insurance under this **certificate**. If such error or delay is found, **we** will adjust the premium fairly.

Conformity with Statutes
Any provision in this **certificate** that is in conflict with the requirements of any state or federal law that apply to this **certificate** are automatically changed to conform to the minimum requirements of such laws.

Entire Contract; Changes
The **policy,** this **certificate**, including the application, endorsements, amendments and any attached papers constitutes the entire contract of insurance. No change in this **certificate** will be valid until approved by one of **our** executive officers and endorsed on or attached to this **certificate**. No agent has authority to change this **certificate** or to waive any of its provisions.

Incontestability
The validity of the **policy** will not be contested after it has been in force for 3 years from the **policy** Effective Date, except for non-payment of premium or fraudulent misstatement. **We** reserve the right to contest coverage at any time based upon the **covered person's** ineligibility for coverage under this **certificate** or upon other provisions of the **certificate**.

Misstatement of Material Fact
If the **policyholder** has misstated any material fact, all amounts payable under this **certificate** will be such as the premium paid would have purchased had such fact been correctly stated.

Noncompliance with Certificate Requirements
Any express or implied waiver by **us** of any requirements of this **certificate** is not a continuing waiver of such requirements. Any failure by **us** to enforce any **certificate** provision will not be a waiver or amendment of that provision.

Non-Participating:
This **certificate** is non-participating. It does not share in the **company's** profits or surplus earnings.

Certificate Changes
No change in this **certificate** will be valid until approved by one of **our** executive officers and endorsed on or attached to this **certificate**. **We** may agree with the **policyholder** to modify a plan of benefits without the **covered person's** consent.

Workers' Compensation Insurance
This **certificate** is not in place of and does not affect any requirements for coverage under any Workers' Compensation law.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

Effective: August 01, 2019

This Notice of Privacy Practices (" Notice") applies to **Wellfleet Insurance Company** and **Wellfleet New York Insurance Company**'s (together, " w e", **"**us" or " our") insured health benefits plans. We are required to provide you with this Notice.

Personal Information is information that identifies you as an individual, such as your name and Social Security Number, as well as financial, health and other information about you that is nonpublic, and that we obtain so we can provide you with insurance coverage.

Protected Health Information (your "Health Information") is information that identifies you as related to your physical or mental health, your health care, or payment for your healthcare.

Our Responsibilities

We are required by law to maintain the privacy of the Health Information we hold and to provide you with this Notice and to follow the duties and privacy practices described in this Notice. We are required to abide by the terms of this Notice currently in effect.

We utilize administrative, technical, and physical safeguards to protect your information against unauthorized access and against threats and hazards to its security and integrity. We comply with all applicable state and federal rules pertaining to the security and confidentiality of your information.

We will promptly inform you if a breach has occurred that may have compromised the privacy or security of your Health Information.

Overview of this Notice

This Notice describes how certain information about you may be used and disclosed and how you can get access to this information. This Notice addresses three primary areas:

- An overview of Your Health Information. This section addresses how we collect your information, how we use it to run our business, and the reasons we share it.
- Your Rights. This section gives an overview of the rights you have with respect to your information we have in our records.
- How to Contact Us. In case you have any questions, requests, or even if you feel you need to make a complaint, we want to make sure you are in contact with the right person.

YOUR HEALTH INFORMATION

How We Acquire Your Information

In order to provide you with insurance coverage, we need Personal Information about you. We gather this information from a variety of sources including your employer, your health care provider, your school, other insurers, and third party administrators (TPAs). This information is necessary to properly administer your health plan benefits.

How We use Your Health Information

Below are some examples of how we use and disclose your Health Information. Broadly, we will use and disclose your Health Information for Treatment, Payment and Health Care Operations.

Treatment refers to the health care treatment you receive. We do not provide treatment, but we may disclose certain information to doctors, dentists, pharmacies, hospitals, and other health care providers who will take care of you. For example, a doctor may send us information about your diagnosis and treatment so we can develop a health care plan and arrange additional services.

Payment refers to activities involving the collection of premiums, payment of claims, and determining covered services. For example, we may review your Health Information to determine if a particular treatment is medically necessary and what that payment for the services should be.

Health Care Operations refers to the business functions necessary for us to operate, such as audits, complaints responses and quality assurance activities. For example, we would use your Health Information (but not genetic information) for underwriting and calculating rates, or we may use your Health Information to detect and investigate fraud.

Additionally:

- We may **confirm enrollment** in the health plan with the appropriate party.
- If you are a **dependent** of someone on the plan, we may disclose certain information to the plan's subscriber, such as an explanation of benefits for a service you may have received.
- We may share enrollment information, payment information, or other Health Information in order to coordinate treatment or other services you may need.

We may disclose your information when instructed to do so, including:

- **Health oversight activities** may require that we disclose your information to governmental, licensing, auditing and accrediting agencies;
- **Legal proceedings** may require disclosure of your Health Information in response to a court order or administrative order, or in response to a subpoena, discovery request, warrant, summons, or other valid process;
- **Law enforcement activities** might require disclosure of certain Health Information to local, state or federal law enforcement, so long as the release is authorized or required by law;
- **As required by law** or to avert a serious threat to safety or health; and,
- To **certain government agencies**, such as the Department of health and Human Services or the Office of Civil Rights if they are conducting an investigation or audit.

Authorizations

Occasionally we may receive a request to share your information in a manner outside of how we normally use your Health Information, as described above. In those cases, we will ask you for your authorization before we share your Health Information.

YOUR RIGHTS

You have the **right to request restrictions** on certain uses and disclosures of your Health Information, including the uses and disclosures listed in this Notice and disclosures permitted by law. You also have the **right to request that we communicate with you in certain ways**.

- We will accommodate reasonable requests;
- We are not required to agree to a request to restrict a disclosure unless you have paid for the cost of the health care item or service in full (i.e., the entire sum for the procedure performed) and disclosure is not otherwise required by law; and,
- If you are a minor, depending on the state you reside in, you may have the right in certain circumstances to block parental access to your Health Information. For example, a minor may have the rights of an adult with respect to diagnosis and care of conditions such as STDs, drug dependency, and pregnancy.

You have the **right to inspect and copy your Health Information** in our records. Please note that there are exceptions to this, such as:

- Psychotherapy notes;
- Information complied in reasonable anticipation, or for use in, a civil, criminal or administrative action or proceeding;
- Health Information that is subject to a law prohibiting access to that information; or,
- If the Health Information was obtained from someone other than us under a promise of confidentiality and the access request would be reasonably likely to reveal the source of the information.

We may deny your request to inspect and copy your Health Information if:

- A licensed health care professional has determined your requested access is reasonably likely to endanger your life or physical safety of another;
- The Health Information makes reference to another person and a licensed health care professional has determined that access requested is reasonably likely to cause substantial harm to another; or,
- A licensed health care professional has determined that access requested by your personal representative is likely to cause substantial harm to you or another person.

You have the **right to request an amendment** to your Health Information if you believe the information we have on file is incomplete or inaccurate. Your request must be in writing and must include the reason for the request. If we deny your request, you may file a written statement of disagreement.

You have the right to know who we have provided your information to - - this is known as an **accounting of disclosures**. A request for an accounting of disclosures must be submitted in writing to the address below. The accounting will not include disclosures made for treatment, payment, health care operations, for law enforcement purposes, or as otherwise permitted or required by law. If you request an accounting of disclosures more than once in a twelve (12) month period we may charge a reasonable fee to process, compile and deliver the information to you this second time.

You have a **right to receive a paper copy of this Notice**. Simply call the customer service line indicated on your ID card and request a paper copy be mailed to you. You may also submit a written request to us at the address below.

You will receive a notice of a breach of your Health Information. You have the **right to be notified of a breach** of unsecure Health Information.

Finally, you have the **right to file a complaint** if you feel your privacy rights were violated. You may also file a complaint with the Secretary of Health and Human Services.

CONTACT

For all inquiries, requests and complaints, please contact:

Privacy and Security Officer
Wellfleet Insurance Company/
Wellfleet New York Insurance Company
c/o Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369

In California
c/o Wellfleet Group, LLC
dba Wellfleet Administrators, LLC
PO Box 15369
Springfield, MA 01115-5369

This Notice is Subject to Change

We may change the terms of this notice and our privacy policies at any time. If we do, the new terms and policies will be effective for all of your Health Information we maintain, as well as any information we may receive or maintain in the future.

Please note that we do not destroy your Health Information when you terminate your coverage with us. It may be necessary to use and disclose this information for the purposes described above even after our coverage terminates, although policies and procedures will remain in place to protect against inappropriate use and disclosure.

Gramm-Leach-Bliley ("GLB") Privacy Notice

We understand your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of *nonpublic personal information* ("NPI"). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

COLLECTING YOUR INFORMATION

We collect NPI about our customers to provide them with insurance products and services. This may include your name, Social Security number, telephone number, address, date of birth, gender, work/school enrollment history, and health history. We may receive NPI from your completing the following forms:

- Claims forms
- Enrollment forms
- Beneficiary designation/Assignment forms
- Any other forms necessary to effectuate coverage, administer coverage, or administer and pay your claims

We also collect information from others that is necessary for us to properly process a claim, underwrite coverage, or to otherwise complete a transaction requested by a customer, policyholder or contract holder.

SHARING YOUR INFORMATION

We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization such as a policyholder's or contract holder's broker, a third-party administrator, reinsurer, employer, school, or plan sponsor. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

We do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

HEALTH INFORMATION

We will not share any of your protected health information ("PHI") unless allowed by law, and/or you have provided us with the appropriate authorization. Additional information on how we protect your PHI can be found in the Notice of Privacy Practices.

SAFEGUARDING YOUR INFORMATION

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees or authorized individuals who need to know the NPI to provide insurance products or services to you. Our employees are continually trained on how to keep information safe.

ACCESSING YOUR INFORMATION

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our processing costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

CORRECTING YOUR INFORMATION

If you believe the NPI we have about you is incorrect, please write to us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two (2) years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two (2) years.

CONTACTING US

If there are any questions concerning this notice, please feel free to write us at:

Privacy and Security Officer
Wellfleet Insurance Company
c/o Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369

In California
c/o Wellfleet Group, LLC
dba Wellfleet Administrators, LLC
PO Box 15369
Springfield, MA 01115-5369

NOTICE OF NON-DISCRIMINATION AND ACCESSIBIILITY REQUIREMENTS

The Company complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Company does not exclude people or treat them worse because of their race, color, national origin, age, disability, or sex.

The Company provides free aids and services to people with disabilities to communicate effectively with us, such as:

1. Qualified sign language interpreters
2. Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose first language is not English when needed to communicate effectively with us, such as:

1. Interpreters
2. information translated into other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Wellfleet Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator,
PO Box 15369
Springfield, MA 01115-5369
(413) 733-4540
civilcoordinator@wellfleetinsurance.com

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
800-868-1019; 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ADVISORY NOTICE TO POLICYHOLDERS

U.S. TREASURY DEPARTMENT'S OFFICE OF FOREIGN ASSETS CONTROL ("OFAC")

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 Declarations page for complete information on the coverages you are provided.

This Policyholder Notice provides information concerning possible impact on your insurance coverage due to the directives issued by OFAC and possibly by the U.S. Department of State. **Please read this Policyholder Notice carefully.**

OFAC of the U.S. Department of Treasury administers and enforces economic and trade sanctions policy 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 found on the U.S. Department of Treasury's website (www.treas.gov/ofac)

In accordance with OFAC regulations, or any applicable regulation promulgated by the U.S. Department of State, if it is determined that you or another insured, or any person or entity claiming the benefits of this insurance has violated U.S. sanctions law or is identified by OFAC as a *Specially Designated National* or *Blocked Person*, this insurance will be considered a blocked or frozen contract and all provisions of this insurance will be immediately subject to OFAC. When an insurance policy is considered to be such a blocked or frozen contract, neither payments nor premium refunds may be made without authorization from OFAC. Other limitations on the premiums and payments also apply.

LANGUAGE ASSISTANCE PROGRAM

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call (877) 657-5030.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al (877) 657-5030.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請致電：(877) 657-5030.

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi (877) 657-5030.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. (877) 657-5030번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa (877) 657-5030.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по номеру (877) 657-5030.

هيبنتنا: اذإ تنكن تدحتنا **ةيبرعلا (Arabic)**، نإف تامدخ ةدعاسملا ةيوغللا ةيناجملا ةحاتم كل. ءاجرلا لاصتلاا بـ 657-5030 (877).

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan (877) 657-5030.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le (877) 657-5030.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer (877) 657-5030.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para (877) 657-5030.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero (877) 657-5030.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie (877) 657-5030 an.

注意事項：日本語 **(Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。(877) 657-5030 にお電話ください。

ی‌سراف امشن‌ابز رگا :هجوت **(Farsi)** دشاب یم امش رایتخا رد نگیار روط هب ی‌نابز دادما تامدخ ،تسا.
(877) 657-5030 تمسا بیگرید.

कृपया ध्या द□: य□द आप □**हंद□ (Hindi)** भाषी ह□ तो आपके □लए भाषा सहायता सेवाएं□न:शुल् उपलब् ह□। कृपया पर काल कर□ (877) 657-5030

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau (877) 657-5030.

ប្រយ័ត្ន៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ**(Khmer)** សេវាកម្មភាសាជំនួយឥតគិតថ្លៃមានសម្រាប់អ្នក។

សូមទូរស័ព្ទមកលេខ (877) 657-5030 ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti (877) 657-5030.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' (877) 657-5030 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac (877) 657-5030

ગુજરાતી (Gujarati) ચુ ના: જો તમે જરાતી બોલતા હો, તો ન:લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો (877) 657-5030

λληνικά (Greek)ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε (877) 657-5030

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (877) 657-5030

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ(877) 657-5030

ਪੰਜਾਬੀ (Punjabi) ਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ (877) 657-5030

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ,
ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (877) 657-5030