Underwritten By:

WELLFLEET

ahp | Academic HealthPlans™

Student Accident Insurance Plan 2021-2022

Policy Number: WI2021TXRISK84

The University of Texas System
FOURTEEN INSTITUTIONS. UNLIMITED POSSIBILITIES.

2020UTSE-B
AHP-BRO(21) WF-UTSE

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

WELLFLEET INSURANCE COMPANY

To get information or file a complaint with your insurance company or HMO:

Call: Wellfleet Group, LLC at
Toll-free: 877-657-5030
Online:
https://wellfleetstudent.com/contact/
Email: appeals@wellfleetinsurance.com
Mail: P.O. Box 15369
Springfield, MA 01115-5369

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

WELLFLEET INSURANCE COMPANY

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Wellfleet Group, LLC at al

Teléfono gratuito: 877-657-5030

En línea: https://wellfleetstudent.com/contact/
Correo electrónico: appeals@wellfleetinsurance.com
Dirección postal: P.O. Box 15369
Springfield, MA 01115-5369

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

WELLFLEET INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

BLANKET ACCIDENT INSURANCE POLICY

POLICYHOLDER:	UNIVERSITY OF TEXAS SYSTEM SPECIAL EVENTS INSURANCE (**Policyholder**, You, or Your)
POLICY NUMBER:	MP0000757926
POLICY EFFECTIVE DATE:	August 1, 2021
POLICY TERM:	August 1, 2021 through July 31, 2022
STATE OF ISSUE:	Texas
POLICY ANNIVERSARY:	August 1

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**.

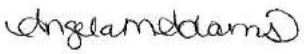
Premium due dates
Premium is due on the **premium due date** immediately following the date We invoice You.

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

THIS IS A LIMITED POLICY WHICH PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENTS ONLY. IT DOES NOT PAY BENEFITS FOR LOSS CAUSED BY SICKNESS.
THIS POLICY CONTAINS A DEDUCTIBLE
PLEASE READ THIS POLICY CAREFULLY
NON-PARTICIPATING

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

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
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
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 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.

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 **effective date** to the **termination date** of this **policy** as shown on the cover page.

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 31 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 60 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**;
3. The **policyholder** fails to provide sufficient information, as required by **Us**, to confirm adequacy of **premiums** and rates currently being paid.

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** if You give Us 31 days advance written notice. The notice must include the **termination date**. The **termination date** shall not be earlier than 31 days after the date of the notice unless You and We agree. 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, **Covered Persons**, and We continue to be responsible following termination for the duties We each incur 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, **Covered Persons**, and We also continue to be responsible for Your, their, and Our duties that this **policy** states are to occur following termination.

You, **Covered Persons**, 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** satisfactory to **Us** 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.

Certificates

Where required by law, 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 satisfy 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. All statements made by the policyholder or by the **covered person** are deemed representations and not warranties. No written statement made by an **covered person** will be used in any contest unless a copy of the statement is furnished to the **covered person** or, in the event of the death or incapacity of the **covered person**, to his beneficiary or personal representative.

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 satisfactory 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.

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 Assets Control (OFAC) license. For more information, visit http://www.treasury.gov/resource-center/sanctions/pages/default.aspx.

Incontestability

The validity of this **policy** may not be contested after it has been in forced for 2 years from the **policy Effective Date**, and in the absence of fraud, a statement made by any individual covered by the **policy** relating to the individual's insurability may not be used in contesting the validity of this **policy** with respect to which the statement was made, after the insurance has been in force before the contest for two years during the individual's lifetime and unless the statement is contained in a written instrument signed by the individual making the statement.

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
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 **providers** 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.

Policies and Procedures

We have the right to adopt reasonable policies, procedures, and rules of this **policy** in order to promote orderly and efficient administration.

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, RIDERS AND AMENDMENTS, IF ANY, THAT IS ATTACHED TO, AND MADE A PART OF THIS POLICY.

WELLFLEET INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

BLANKET ACCIDENT INSURANCE CERTIFICATE

POLICYHOLDER:	UNIVERSITY OF TEXAS SYSTEM SPECIAL EVENTS INSURANCE
POLICY NUMBER:	MP0000757926
POLICY EFFECTIVE DATE:	August 1, 2021
POLICY TERM:	August 1, 2021 through July 31, 2022
STATE OF ISSUE:	Texas
POLICY ANNIVERSARY:	August 1

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.

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**.

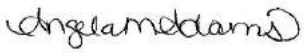
The **certificate** and the coverage provided by it terminates at 11:59 P.M. at the address of the **policyholder's** unless the **policyholder** and **we** agreed to continue coverage under the **policy** for an additional **policy** term. The following pages form a part of this **certificate** as fully as if the signatures below were on each page.

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 LOSS CAUSED BY SICKNESS.
THIS CERTIFICATE CONTAINS A DEDUCTIBLE
PLEASE READ THIS CERTIFICATE CAREFULLY
NON-PARTICIPATING

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.
THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

SIGNED FOR WELLFLEET INSURANCE COMPANY



Andrew M. DiGiorgio, President

Angela Adams, Secretary

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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	**all participants of the policyholder**

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS	
Principal Sum	$50,000
Loss must occur within	365 days of the covered accident
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 Speech	50% of the **Principal Sum**
Loss of Hearing in both ears	50% of the **Principal Sum**
Exposure and Disappearance	
Benefit Limit	**Principal Sum**

ACCIDENT MEDICAL BENEFITS

Any benefit limits and coinsurances for *Accident Medical Benefits* apply, unless otherwise specified, on a per covered accident basis. Any applicable deductibles must be satisfied within the time periods specified before benefits are payable.

The **covered injury** must result directly and independently of all other causes 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 reasonable charges.

SCOPE OF COVERAGE APPLICABLE TO ACCIDENT MEDICAL BENEFITS	
Full Excess Medical Maximum	$100,000 per **covered accident**
Accident Medical **Coinsurance**	100% of **usual and reasonable charges**
Individual **disappearing** Medical **deductible**	$50 per **covered accident**
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	60 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 **coinsurance amount** shown above after the Individual medical **deductible** is met
Skilled nursing facility	The **coinsurance amount** shown above after the Individual medical **deductible** is met
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 **coinsurance amount** shown above after the Individual medical **deductible** is met
Outpatient Hospital Services	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Emergency Room Expenses	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Home Health Care	The **coinsurance amount** shown above after the Individual medical **deductible** is met
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 **coinsurance amount** shown above after the Individual medical **deductible** is met
Maximum Number of days	90 per **covered accident**
Physician Services	
Surgery	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Assistant Surgeon	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Urgent Care Expenses	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Second Opinion or Consultation	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Physician Assistant	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Anesthesia and its Administration	The **coinsurance amount** shown above after the Individual medical **deductible** is met
In-Hospital or Office Visits	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Outpatient X-ray, CT Scan, MRI and Laboratory Tests	
Outpatient X-Rays, CT Scans & MRIs and Laboratory Tests	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Outpatient Services and Supplies	
Outpatient Physical Therapy	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Maximum Visits Per Day	1
Maximum **physical therapy** visits	20 per **covered accident**
Outpatient Occupational and Speech Therapy	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Maximum Visits Per Day	1
Maximum **Occupational and Speech Therapy** visits separate	20 per **covered accident** separate
Nursing Services- Private Duty Nursing	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Ambulance Services	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Ground Ambulance Maximum	$2,000 per trip
Air/Water Ambulance Maximum	$10,000 per trip
Durable Medical Equipment and Orthopedic Braces and Appliances	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Medical Services and Supplies	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Prosthetic or Orthotic Devices	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Dental Services	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Prescription Drugs	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Eyeglasses, Contact Lenses, Hearing Aids, Artificial Dental Devices	The **coinsurance amount** shown above after the Individual medical **deductible** is met

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**.

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**.

Coinsurance means the percentage of **usual and reasonable charges we** pay for **covered expenses** that are **incurred** by the **covered person** after the **covered person** satisfies any applicable **deductible**. **Coinsurances** are shown in the *Schedule of Benefits*.

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

Covered Accident is an **accident** that results, directly and independently of all other causes, 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 contributed to by disease, **sickness**, or mental or bodily infirmity;
4. 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 reasonable** 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, directly and independently of all other causes, from a **covered accident** and occurs while such a person is participating in a **covered activity**. A **covered injury** does not include aggravation of an injury sustained before the **covered accident**.

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**.

Daily Living Services means cooking, feeding, bathing, dressing and personal hygiene services performed by a **home health aide** which are necessary to the **covered person's** care and health.

Deductible means the amount of **covered expenses** that the **covered person** must **incur**, as applicable, before benefits are paid under this **certificate**. The **deductible** may apply to each **covered accident** or each **policy term**, as shown in the *Schedule of Benefits*.

Disappearing Deductible means a dollar amount of **covered expenses** the **covered person** must pay before **we** pay any benefits under this **certificate**. The Deductible may be satisfied by other valid and collectible insurance or plan. The **disappearing deductible** is shown on the *Schedule of Benefits*.

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.

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 the **home health care plan** is established; and
2. Is engaged primarily in providing **skilled nursing facility** services and other 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, or who provides **daily living services**; and
2. Reports to and is under the direct supervision of a **home health care agency**.

Home Health Care means the continued care and treatment of the **covered person** if:
1. Institutionalization would have been required if **home health care** was not provided; and
2. The **covered person's physician** establishes and approves in writing the plan of treatment covering the **home health care** service.

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 directly and independently of all other causes 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**.

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 the **company**, for the purpose of evaluating, diagnosing or treating a **covered injury** sustained as the direct 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**;
4. Not primarily for the **covered person's** convenience, the **covered person's physician** or any other **physician**; and
5. 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.

Nurse means a licensed Registered **Nurse** (R.N.) or a Licensed Practical **Nurse** (L.P.N.) who:

1. Is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and
2. Provides medical services which are within the scope of the Nurse's license or certificate.

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, Preferred Provider Organizations** and other prepayment, group practice an 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.

Physical Therapy means any form of **physical therapy**, whether by machine or hand, by use of exercise, manipulation, massage, adjustment, heat or cold, air, light, water, electricity or sound.

Physician means an individual licensed to practice medicine within the scope of his or her license and is duly licensed by the appropriate state regulatory agency to perform a particular service which is covered under this **Certificate,** and who is not:

1. A person providing homeopathic, aroma-therapeutic, or herbal therapeutic 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 in this **certificate**.

Principal Sum means the amount payable for each Insured 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.

Sickness means a physical or mental illness, including pregnancy.

Skilled Nursing Facility means an institution operating pursuant to applicable law and engaged in providing, for a fee, **inpatient skilled nursing care** and related services and **physical therapy** services under the supervision of a **physician** and registered **nurses**. A **skilled nursing facility** must maintain medical records on all its patients. Treatment rendered in a **skilled nursing facility** does not include routine custodial care.

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 Reasonable Charge means the normal charge, in the absence of insurance, made by the provider of any **medically necessary** care, service or supply, but not more than the prevailing charge in the area:

1. For a like service by a provider with similar training or experience; or
2. For a supply that is identical or substantially equivalent.

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;
2. The date the person becomes eligible.

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; and
2. The date the **covered person** enters full time active duty in any Armed Forces. **We** will refund any premium paid for any period of active duty when **we** receive proof of active duty. Active duty does not include Reserve or National Guard duty for training; and
3. The end of the period for which the last premium is made, subject to the Grace Period; and
4. The date this **certificate** ends.

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**, subject to Extension of Benefits; and
2. The date benefits equal to any applicable Benefit Limit, as shown in the *Schedule of Benefits*, have been paid.

Extension of Benefits: Coverage under this Certificate ceases on the Termination Date. However, your coverage will be extended as follows:

If You are **Hospital** confined for a **Covered Injury** on the date your insurance terminates, we will continue to pay benefits for at least the lesser of:

1. 90 days; or
2. the duration of the hospital confinement.

If you are **Totally Disabled** as a result of a **Covered Injury** on the date your insurance terminates, we will continue to pay benefits for at least the lesser of:

1. 90 days;
2. the duration of the **totally disability**.

Proof of **total disability** may be required at any time.

"**Total Disability**" or "**Totally Disabled**," for the purposes of this Extension of Benefits provision only, means:

1. your complete inability by reason of **Injury** from a **covered accident** to perform all of the substantial and material duties and functions of your occupation and any other gainful occupation in which you earn substantially the same compensation earned before the disability; and
2. confinement in a hospital.

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 or indirectly, in whole or in part, is caused by or 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. Injuries compensable under Workers' Compensation law or any similar law.

3. professional services rendered by an Immediate Family Member or anyone who lives with You, except services rendered by a dentist.
4. Declared or undeclared **war** or act of **war**.
5. Commission or attempt to commit a felony or an assault.
6. Commission of or active participation in a riot or insurrection.
7. Aggravation, during a **covered activity**, of an injury the **covered person** suffered before participating in that **covered activity**, unless **we** receive a written medical release from the **covered person's physician.**
8. 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.
9. Flight in, boarding or alighting from an aircraft, except as:
    a. A fare-paying passenger on a regularly scheduled commercial or charter airline;
    b. A passenger in a military aircraft flown by the Air Mobility Command or its foreign equivalent.
10. Travel in or on any on-road and off-road motorized vehicle that does not require licensing as a motor vehicle.
11. 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.
12. **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.
13. **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.
14. 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.
15. Treatment in any Veteran's Administration, Federal, or state facility, unless there is a legal obligation to pay.
16. Examination or prescriptions for, or purchase, repair or replacement of, eyeglasses, contact lenses except due to a **covered accident** as described elsewhere in this **certificate**.
17. Hearing aids, or purchase, repair or replacement of except due to a **covered accident** as described elsewhere in this **certificate.**
18. Wheelchairs, braces, appliances, orthopedic braces, or orthotic devices except due to a covered accident as described elsewhere in this certificate.
19. A cardiovascular **accident** or stroke resulting, directly and in dependently of all other causes, from exertion, as verified by a **physician.**
20. 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.
21. Rest cures, long-term care or custodial care.
22. 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**.

23. 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.
24. Services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay.
25. Repair or replacement of existing dentures, partial dentures, braces or bridgework, unless damaged or destroyed in a **covered accident**.
26. Treatment or services provided by the **covered person's immediate family**, except services rendered by a dentist.
27. Personal services, or comfort/convenience items such as television and telephone or transportation.
28. Orthopedic appliances used mainly to protect an injury.
29. Expenses payable by any automobile insurance **policy** without regard to fault.
30. Services or treatment provided by an infirmary operated by the **policyholder**.
31. Treatment of injuries that result over a period of time (such as blisters, tennis elbow, etc.), and that are a normal, foreseeable result of participation in the **covered activity**.
32. Treatment or service provided by a private duty **nurse** except due to a **covered accident** as described elsewhere in this **certificate**.
33. Charges for hot or cold packs.
34. Custodial Care service and supplies.
35. Expenses that are not recommended and approved by a **physician**.
36. Repair or replacement of existing artificial limbs, eyes and larynx, unless damaged or destroyed in a **covered accident**.
37. Treatment of hernia of any kind. Hernia means a rupture or protrusion of an organ or part through connective tissues or through a wall of a cavity in which it is normally enclosed.
38. Treatment of an injury resulting from or contributed to by frostbite, fainting or seizures, or heatstroke or heat exhaustion.
39. Participation in any sports activity not specifically authorized, sponsored and supervised by the **policyholder**, whether or not it takes place on **policyholder** premises.
40. Any expenses in excess of **usual and reasonable charges** except as provided in this **certificate**.
41. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
42. Racing or speed contests, skin diving, or sky diving, mountaineering (where ropes or guides are customarily used), parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles), or other hazardous sport or hobby.
43. Non-physical, occupational, speech therapies (art, dance, etc.).
44. Modifications made to dwellings.
45. General fitness, exercise programs.

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 directly 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
   c. 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; or
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
   b. While on a sponsored, sanctioned and/or supervised **covered activity**, if the sponsored, sanctioned and/or supervised activity is located within or outside the contiguous United States, Alaska, Hawaii and the territories and possessions of the United States, Canada or Mexico including travel while participating in a **covered activity** that requires an overnight stay; and
   c. In a vehicle which is:
      i. Designated or furnished by the **policyholder**;
      ii. Operated by a properly licensed adult driver; and
      iii. Under the direct supervision of the **policyholder.**

Definitions for the purposes of this coverage:

Travel Time means the time:

1. To or from the **covered person's** Home, the **policyholder** location or premises and/or the **sponsored, sanctioned and/or supervised activity** of the **policyholder**;
2. Before the start of the **sponsored, sanctioned and/or supervised activity** of **policyholder**; and
3. After the **sponsored, sanctioned and/or supervised activity** of the **policyholder** is completed.

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

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

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 directly and independently of all other causes 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**.

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 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.

Severance means complete separation and dismemberment of the part from the body.

Exposure and Disappearance Coverage

We will pay benefits if the **covered person** suffers a **covered injury** from a **covered accident** that results in the **covered person's** unavoidable exposure to the elements following a **covered accident** and as a result of such exposure the **covered person** suffers a **Covered Loss** for which an **Accidental Death** or **Accidental Dismemberment benefit** would otherwise be payable under this **certificate,** the **Covered Loss** will be covered under the **Accidental Death** or **Dismemberment** portion of the **certificate.**

If the **covered person** disappears and is not found within one year from the date of the **covered accident**, the forced landing, sinking, stranding or wrecking of a vehicle in which the person was an occupant while covered under this **certificate**, it will be presumed that the **covered person's** death resulted directly and independently of all other causes from a **covered accident.** This **certificate** will pay an **Accidental Death** benefit that would have been payable under the **certificate**.

Extension of Benefits - In the event you are **Totally Disabled** on the date coverage would otherwise end, an extension of benefits will be provided:

- for any loss of time from work because of the disability, if applicable; or
- during a period of confinement in a hospital.

We will continue to pay benefits for at least the lesser of:

1. 90 days;
2. the duration of the **total disability**.

Proof of Total Disability may be required at any time.

"**Totally Disabled**," for the purposes of this **Extension of Benefits** provision only, means:

1. your complete inability by reason of **Injury** from a **covered accident** to perform all of the substantial and material duties and functions of your occupation and any other gainful occupation in which you earn substantially the same compensation earned before the disability; and
2. confinement in a hospital.

ACCIDENT MEDICAL EXPENSE BENEFITS

This Section describes the Scope of Coverage for which Medical Benefits are payable. Any applicable coinsurances, benefit deductibles, benefit periods, benefit limits and maximums are shown in the *Schedule of Benefits.* Please read these, 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 directly and independently of all other causes from a covered accident.

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

Full Excess Medical Expense

We will pay **covered expenses**, up to the Full Excess Medical Benefit shown in the *Schedule of Benefits* after the **covered person** satisfies any **deductible**, 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** and after the **covered person** satisfies any applicable **deductible.**

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 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**.

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 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

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**.

Skilled nursing facility

We will pay **covered expenses incurred** by the **covered person** for treatment of a **covered injury** in a **skilled nursing facility.**

Confinement in such Facility must:

1. Be in in lieu of an Inpatient **hospital stay** on a full-time basis; and
2. Be preceded by a Minimum Inpatient **hospital stay**, as specified in the *Schedule of Benefits*; and
3. Begin within 72 hours following the Inpatient **hospital stay**; and
4. Include treatment for which a **physician** visits the **covered person** at least once every 30 days.

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 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 medical or surgical treatment.

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**.

Home Health Care

We will pay **covered expenses incurred** by the **covered person** for care and treatment rendered to the **covered person** by a **home health care agency**, for:

1. Part-time nursing care by or supervised by a registered graduate **nurse**;
2. Part-time **home health aide** service which consists of caring for the patient;
3. Physical, speech and occupational therapies when indicated in conjunction with the **covered person's** discharge placement through a **rehabilitation facility** approved by the attending **physician** and by **us**;
4. Nutritional counseling;
5. Medical social services by a qualified social worker licensed by the jurisdiction in which services are rendered.

Home health care services must be preceded by a Minimum **Inpatient hospital stay** and must begin within the specified number of consecutive days of discharge from a **hospital** or **skilled nursing** or **rehabilitation facility**. The Minimum **Inpatient hospital stay** and the number of consecutive days within which **home health care** must begin are shown in the *Schedule of Benefits*.

For the purpose of determining the number of **home health care** visits payable, each visit by a member of a **home health care agency** shall be considered as one **home health care** visit. Up to 4 hours of **home health aide** service shall also be considered as one **home health care** visit.

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.

Surgery

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
    - 50% 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:

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

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

Prosthetic Devices and Orthotic Devices

We will pay **covered expenses incurred** for prosthetic devices, orthotic devices, and professional services related to the fitting and use of those devices. The covered benefits are limited to the most appropriate model of prosthetic or orthotic devices that adequately meets the medical needs as determined by the treating Physician or podiatrist and prosthetist or orthotist.

"Orthotic device" means a custom-fitted or custom-fabricated medical device that is applied to a part of the
human body to correct a deformity, improve function, or relieve symptoms of a disease.

"Prosthetic device" means an artificial device designed to replace, wholly or partly, an arm or leg.

Coverage is subject to annual Deductibles, Copayments, and Coinsurance consistent with annual Deductibles, Copayments, and Coinsurance required for other coverage and may not be subject to annual dollar limits. Subject to Copayments and Deductibles, the repair and replacement of a prosthetic or orthotic device is a covered benefit unless the repair or replacement is necessitated by misuse or loss by the covered person.

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 directly and independently of all other causes 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**.

Eyeglasses, Contact Lenses, Hearing Aids, Artificial Dental Devices
We will pay **covered expenses incurred** by the **covered person** for eyeglasses, contact lenses, hearing aids or artificial dental devices when purchase and fitting is necessary to treat a **covered injury** and/or repair or replacement, when damaged in a **covered accident** for which the **covered person** has **incurred** other **covered expenses We** will pay the **covered expenses incurred** for the **Eyeglasses, Contact Lenses, Hearing Aids, Artificial Dental Devices** up to the maximum amount shown in the *schedule of benefits*.

Acquired Brain Injury

Benefits will be paid the same as any other Injury for Medically Necessary services as a result of and related to a brain injury to facilitate the recovery and progressive rehabilitation of survivors of acquired brain injuries to the extent possible to their pre-injury condition.

Treatment for an Acquired Brain Injury may be provided at a facility at which appropriate services may be provided, including:

1) A Hospital, including an acute and a post-acute rehabilitation hospital; and
2) An assisted living facility.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

Definition for purposed of this Condition of Coverage
Acquired brain injury means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

Exclusions provided in this policy do not include limitations or exclusions of therapies listed and defined below. The following therapies must be provided for the coverage of Acquired Brain Injury.

Treatment of an Acquired Brain Injury includes:

a. Cognitive rehabilitation therapy which includes services designed to address therapeutic cognitive activities, based on an assessment and understanding of the Insured Person's brain-behavioral deficits.

b. Cognitive communication therapy which includes services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

c. Neurocognitive therapy which includes services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

d. Neurocognitive rehabilitation which includes services designed to assist cognitively impaired Insured Persons to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

e. Neurofeedback therapy including services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

f. Neurophysiological testing which is an evaluation of the functions of the nervous system.

g. Neurophysiological Treatment which consists of interventions that focus on the functions of the nervous system.

h. Neuropsychological testing which is the administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous
functioning.

i. Neuropsychological Treatment which consists of interventions designed to improve or minimize deficits in behavioral and cognitive processes.

j. Neurobehavioral testing- An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the Insured, family, or others.

k. Neurobehavioral Treatment which consists of interventions that focus on behavior and the variables that control behavior.

l. Outpatient day treatment services – Structured services provided to address functional deficits in behavior and/or cognition delivered in settings that include transitional residential, community integration, or non-residential services.
m. Psychophysiological testing- An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.
n. Psychophysiological Treatment which includes interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
o. Remediation which is the process(es) of restoring or improving specific function.
p. Post-acute transition services which are services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.
q. Community reintegration services which are services that facilitate the continuum of care as an affected Insured Person transitions into the community.
r. Post-acute care treatment services – Services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.
s. Services--The work of testing, treatment, and providing therapies to an individual with an acquired brain injury.
t. Therapy--The scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an acquired brain injury.

Benefits for post-acute care treatment services shall not be included in any policy maximum lifetime limit on the number of days of acute care treatment.

CLAIM PROVISIONS

Notice of Claim
Written or authorized electronic notice must be given to **us** or **Our** agent within 20 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 satisfactory to **us** 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 that time, 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, within 60 days after the date the proof of loss is received. In addition, subject to written proof of loss, all accrued benefits payable under the **policy** for loss of time will be paid at least monthly during the period for which **We** are liable, and any balance remaining unpaid at the end of that period will be paid as soon as possible after the proof of loss is received.

Payment of Claims
All benefits will be paid to the **covered person** or to the **covered person's** designee. 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.

Appeals Procedure
If You have a claim that is denied by Us, You have the right to file a complaint. Your Authorized Representative may act on Your behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination.
Wellfleet
For purposes of this Section, the following definitions apply:
Adverse Benefit Determination means:

- A determination by Us or Our designee Utilization review organization that, based upon the information provided, a request for a benefit under the Policy upon application of any utilization review technique does not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be Experimental or Investigative and

the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;
- The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by Us or Our designee Utilization review organization of Your eligibility under the Policy;
- Any prospective review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit.

Authorized Representative means:
- A person to whom have given express written consent to represent You;
- A person authorized by law to provide substituted consent for You;
- A family member of Yours or Your treating health care professional when You are unable to provide consent;
- A health care professional when the Policy requires that a request for a benefit under the Policy be initiated by the health care professional; or
- In the case of an Urgent Care claim, a health care professional with knowledge of Your medical condition.

Emergency Care means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:
- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part; or
- Serious disfigurement.

Utilization review means a set of formal techniques designed to monitor the use of, or evaluate the Medical Necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, Prospective review, second opinion, certification, Concurrent review, case management, discharge planning or Retrospective review.

Utilization review organization means an entity that conducts Utilization review, other than Us performing utilization review for Our own health benefit plans.

Complaint System

Within 180 days after notice of an adverse determination of a claim, the **covered person**, or an authorized representative may file a written or oral complaint by sending **Us** a written request for review. **We** will review the information and provide a written response within thirty (30) 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.

Notice of Determination

We shall provide a notice of a determination to You, the insurer and Your provider or the health care facility if they requested the review. This will be mail or transmitted electronically no later than the second working day after the date of the request for utilization review and the agent receives all information necessary to complete the review.

If an Adverse Determination is made the written decision shall include:

- the principal reasons for the decision;
- the clinical rationale for the decision;
- a description of the criteria used as guidelines;
- procedure for the complaint and appeal process, including Your right to appeal an adverse determination to an Independent Review Organization (IRO).

For Emergency Care, upon receipt of an appeal, You or Your Authorized Representative will be notified of **Our** determination as soon as possible but no later than one (1) business day, either by telephone or electronic transmission, followed by a letter within three (3) business days. For Life Threatening, upon receipt of an appeal, You or Your Authorized Representative will be notified of **Our** determination as soon as possible but no late than one (1) hour after the request has been made.

For Non-emergency, upon receipt of an appeal, You or Your Authorized Representative will be notified, in writing, of **Our** determination as soon as possible but no later than within three (3) business days.

Retrospective review, as applicable, We shall provide, You or Your Authorized Representative, a written response within thirty (30) calendar days of the receipt of the request.

Complaint as Appeal

A complaint filed concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of that adverse determination.

Appeal of Adverse Determination

If You do not agree with Our decision and wish to appeal, You must file a written or oral appeal with Us at the address above within 180 days of receipt of the notification. Within five (5) business days from the date a written appeal is received We will send to You or Your Authorized Representative a letter acknowledging the date of receipt. When an oral appeal of an adverse determination is received, We will send a one-page appeal form to You or Your Authorized Representative.

No later than 10 business days after the date an appeal is denied Your physician can request in writing a Specialty Review. The specialty review must be completed within 15 business days from the date we received Your physician requested for the specialty review.

You should submit all information referenced above with Your appeal. You should gather any additional information that is identified in the notice as necessary to perfect Your claim and any other information that You believe will support Your claim.

Notice of Appeal

If You do not agree with Our decision and wish to appeal, You must file a written or oral appeal with Us at the address above. We will notify You, in writing, of the determination of the appeal as soon as possible, but no later than 30 calendar days after We have received the appeal.

If an appeal is denied, the notice must include a clear and concise statement of:

- the clinical basis for the denial;

- the specialty of the physician or other health care provider making the denial; and
- Your right to have the denial reviewed by an Independent Review Organization (IRO).

Expedited External Review

You may also seek an expedited external review of an adverse determination of Emergency Care or continued hospitalization. The expedited external review will include a review by a health care provider who:

- has not previously reviewed the case;
- is of the same or similar specialty as the health care provider who would typically review the appeal.

You or Your Authorized Representative will be notified of the determination of this appeal no later than 1 business day from the date all information necessary to complete the appeal is received.

If Your appeal is denied based on medical judgement such as Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or Treatment and You wish to seek an external review from an Independent Review Organization (IRO), You must file a written or oral request for external review.

Independent Review Organization (IRO) for a Life-Threatening Circumstance

Immediate appeal to an IRO for a Life-Threatening circumstance. You are entitled to an immediate appeal to an IRO and You are not required to comply with the above procedures.

No later than three (3) business days after the date We receive a request for IRO, We shall provide to the appropriate independent review organization:

- a copy of:
  (A) any medical records that are relevant to the review;
  (B) any documents used by Us in making the determination to be reviewed;
  (C) the written notification described above under Notice of Appeal; and
  (D) any documents and other written information submitted in support of the appeal; and
- a list of each physician or other health care provider who:
  (A) has provided care to You; and
  (B) medical records relevant to the appeal.

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.

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 satisfactory 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 requesting a lump sum payment of the overpaid amount.

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

Subrogation
We have the right to recover all payments including future payments, which **we** have made, or will be obligated to pay in the future, to the **covered person** from anyone liable for the **covered loss**. If the **covered person** recovers payments designated for medical expenses from anyone liable for the **covered loss**, **we** will be reimbursed first from such recovery to the extent of **Our** payments to the **covered person**.

When the **covered person** is not represented by an attorney in obtaining a recovery, **Our** share of the **covered person's** recovery is an amount that is equal to the lesser of:

a. one-half of the **covered person's** gross recovery; or
b. the total cost of benefits paid, provided or assumed by **Us** as a direct result of the third party's wrongful act or negligence.

When the **covered person** is represented by an attorney in obtaining a recovery, **Our** share of the **covered person's** recovery is an amount that is equal to the lesser of:

a. one-half of the **covered person's** gross recovery less attorney's fees and procurement costs as defined under Section 140.007 of the Civil Practice and Remedies Code; or
b. the total cost of benefits paid, provided or assumed by **Us** as a direct result of the third party's wrongful act or negligence less attorney's fees and procurement costs as defined under Section 140.007 of the Civil Practice and Remedies Code.

We are not eligible to recover benefits paid to or on the **covered person's** behalf from a third party except a recovery against uninsured/underinsured motorist coverage or medical payments coverage but only if the **covered person** or the **covered person's** immediate family member did not pay the premiums for the coverage.

The **covered person** agrees to assist **Us** in preserving **Our** rights against those responsible for such loss, including but not limited to, signing subrogation forms supplied by **Us**.

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** satisfactory to **us** 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
Where required by law, 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 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 satisfy 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 this **certificate** may not be contested after it has been in forced for 2 years from the **policy** Effective Date, and in the absence of fraud, a statement made by any individual covered by the **policy** relating to the individual's insurability may not be used in contesting the validity of this **policy** with respect to which the statement was made, unless the statement is contained in a written instrument signed by the individual making the statement.

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 the **company** of any requirements of this **certificate** is not a continuing waiver of such requirements. Any failure by the **company** 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 the **company's** executive officers and endorsed on or attached to this **certificate**. The **company** 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.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Wellfleet Insurance Company's toll-free telephone number for information or to make a complaint at:

[1-877-657-5030]

You may also write to Wellfleet Insurance Company at:

[Wellfleet Group, LLC
2077 Roosevelt Ave
Springfield, MA 01104]

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P. O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:
Should you have a dispute concerning your premium or about a claim, you should contact Wellfleet Insurance Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de Wellfleet Insurance Company's para obtener información o para presentar una queja al:

[1-877-657-5030]

Usted también puede escribir a Wellfleet Insurance Company:

[Wellfleet Group, LLC
2077 Roosevelt Ave
Springfield, MA 01104]

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P. O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Sitio web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:
Si tiene una disputa relacionada con su prima de seguro o con una reclamación,, usted debe comunicarse con Wellfleet Insurance Company primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA:
Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts) **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
    - Up to $500,000 for health benefit plans, with some exceptions.
    - Up to $300,000 for disability income benefits.
    - Up to $300,000 for long-term care insurance benefits.
    - Up to $200,000 for all other types of health insurance.

- **Life insurance:**
    - Up to $100,000 in net cash surrender or withdrawal value.
    - Up to $300,000 in death benefits.

- **Individual annuities:** Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.

- **Individual aggregate limit:** Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.

- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:	For questions about insurance, contact:
Texas Life & Health Insurance Guaranty Association	**Texas Department of Insurance**
515 Congress Avenue, Suite 1875	P.O. Box 149104
Austin, TX 78701	Austin, TX 78714-9104
1-800-982-6362 or www.txlifega.org	1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas life and health insurance guaranty association act (insurance code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included with this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

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 Betsy M. Stevens and John Kelley Civil Rights Coordinators.

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:

Betsy M. Stevens and John Kelley Civil Rights Coordinators,
PO Box 15369
Springfield, MA 01115-5369
(413)-733-4540; (413)-733-4612
Bstevens@wellfleetinsurance.com, or Jkelley@wellfleetinsurance.com.

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance Betsy M. Stevens and John Kelley of Civil Rights Coordinators are 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
800-8681019; 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.

تنبيه: اذا تكنت تتحدث **ةيبرعلا (Arabic)**، نإف تامدخ ةدعاسملا ةيوغللا ةينامجلا 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。

توجه: اگر زبان شما **یسارف (Farsi)** باشد می توانید خدمات ترجمه رایگان در طول ساعات اداری با شماره زیر تماس بگیرید.
(877) 657-5030

कृपा ध्या द□: य□द आप □**हंद**□ **(Hindi)** भाषी ह□ तो आपके □लए भाषा सहायता सेवाएं□न:शुल् उपलब् ह□। कृपा 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 yániłti'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. ໂທ (877) 657-5030