



southwestern
ASSEMBLIES
OF GOD **university**

Including the American Indian College

Waxahachie, Texas

Student Health Insurance Plan 2021-2022

Policy Number: WI2021TXACC19

The 2021-2022 Student Health Insurance Plan is underwritten by Wellfleet Insurance Company, PO Box 15369, Springfield, MA 01115.

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 CERTIFICATE

POLICYHOLDER: Southwestern Assemblies of God University (SAGU)
POLICY NUMBER: WI2122TXACC19
POLICY EFFECTIVE DATE: August 20, 2021
POLICY TERM: August 20, 2021 through August 19, 2022
STATE OF ISSUE: Texas
POLICY ANNIVERSARY: August 20, 2022

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**. 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 LOSSES CAUSED BY SICKNESS.

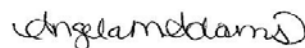
**THIS CERTIFICATE CONTAINS A DEDUCTIBLE
PLEASE READ THIS CERTIFICATE CAREFULLY
NON-PARTICIPATING**

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 student athletes of the policyholder .
Class 2	All students of the policyholder .

COVERED ACTIVITIES:

Class 1	During participation in and/or attendance at the following policyholder scheduled, sponsored, sanctioned, and/or supervised sports activities: Football, Cross Country, Soccer, Basketball, Softball, Baseball, Track & Field, Cheerleading, and Volleyball.
Class 2	During participation in and/or attendance at policyholder scheduled, sponsored, sanctioned, and/or supervised non-Intercollegiate Sports activities.

TYPE OF COVERAGE:

24-Hour Accident-Only Coverage	Eligible Class(es) Class 2
Athletics-Only Coverage	Class 1

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS	
Principal Sum Amount	\$10,000
Loss must occur within	365 days of the covered accident
Accidental Death and Dismemberment Aggregate Limit	Unlimited
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	25% 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	25% of Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Loss of Speech and Hearing (in both ears)	Principal Sum
Loss of Hearing (in both ears)	Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing in one ear	50% of the Principal Sum
Loss of Use of Two or More Hands or Feet	Principal Sum
Loss of Use of One Hand or Foot	50% of the Principal Sum
Quadriplegia	100% of Principal Sum
Paraplegia	100% of Principal Sum
Hemiplegia	100% of Principal Sum
Uniplegia	25% of 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 Accident Medical Maximum	\$25,000 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 Surgical Services	The coinsurance amount shown above after the Individual Medical deductible is met
Outpatient Hospital Non-Surgical 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	
Surgeon Expenses	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's 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	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
Acquired Brain Injury	The coinsurance amount shown above after the Individual medical deductible is met
Other Benefits	
Eyeglasses, Contact Lenses, Hearing Aids, Artificial Dental Devices	The coinsurance amount shown above after the Individual Medical deductible is met
Expanded Medical Benefit for Covered Sports Conditions	Same as any other covered loss
Covered Sports Conditions	bursitis; sprains; hernia; MRSA; muscle tears; tendonitis; stress fractures; shin splints; injury to joints and surrounding muscle and tissue; tennis elbow; and repetitive motion injuries
Heart and Circulatory Conditions	Same as any other covered loss
Covered Heart and Circulatory Conditions	heat exhaustion; heart attack; cardia arrest; stroke; burst aneurysm
Treatment of Hernia	Same as any other covered loss
Re-Agravation of Prior Injury Benefit	Same as any other covered loss

DEFINITIONS

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

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

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

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

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

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

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

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

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**. All **covered expenses** incurred as a result of the same or related cause (including any complications) shall be considered as resulting from one **covered injury**. A **covered injury** includes aggravation of an injury sustained before the **covered accident**, if such aggravation resulted directly and independently of all other causes from a **covered accident**, but only if a **physician** had released the **covered person** to participate in the **covered activity** during which the **covered accident** occurred.

Covered Loss means a loss:

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

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

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** shall apply to each **covered accident**, 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 any **other health care 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.

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

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

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

Home Health Care Agency means an agency that:

1. Is constituted, licensed and operated under the provision of Title XVIII of the Federal Social Security Act, or qualified to be so operated if application was made, and certified by the jurisdiction in which 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 **hospitals** 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 **us**, 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 convenience of the **covered person**, 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.

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

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

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

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

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

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

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 a licensed health care provider practicing within the scope of their license and rendering care and treatment to the **covered person** that is appropriate for the condition and locality, and who is not:

1. The **covered person**;
2. The **covered person's** spouse;
3. A person living in the **covered person's** household;
4. A person employed or retained by the **policyholder**; or
5. 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 on the cover page of this **certificate**.

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

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

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

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

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

School means the participating **school** where the **covered person** is enrolled. The **school** must be licensed or accredited, as applicable, by the jurisdiction where it is located, to provide the care, education or training for which the **covered person** is enrolled. A college or university that is a member of an **intercollegiate** athletic association.

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.

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

Surgical Procedure means:

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

Usual and 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; or
2. The date the person becomes a member of an eligible class of persons as described in the Description of Class section of the Schedule of Benefits.

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

TERMINATION OF INSURANCE

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

1. The date the **covered person** is no longer in an Eligible Class; or
2. The date coverage for the Eligible Class of which the **covered person** is a member ends; or
3. 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; or
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. **Sojourns or Personal deviations**.
4. professional services rendered by an Immediate Family Member or anyone who lives with You, except services rendered by a dentist.
5. Declared or undeclared **war** or act of **war**.
6. Commission or attempt to commit a felony or an assault.
7. Commission of or active participation in a riot or insurrection.

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 fare-paying passenger on a regularly scheduled commercial or charter airline.
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. **Medical** or **surgical** treatment, diagnostic procedure, administration of anesthesia, unless it occurs during treatment of injuries sustained in a **covered accident**.
14. Travel or activity outside the United States and the territories and possessions of the United States.
15. **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.
16. 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.
17. Treatment in any Veteran's Administration, Federal, or state facility, unless there is a legal obligation to pay.
18. 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**.
19. Hearing aids, or purchase, repair or replacement of, except due to a **covered accident** as described elsewhere in this **certificate**.
20. Wheelchairs, braces, appliances, orthopedic braces, or orthotic devices except due to a covered accident as described elsewhere in this certificate.
21. 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.
22. Rest cures, long-term care or custodial care.
23. 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**.
24. 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.
25. Services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay.
26. Repair or replacement of existing dentures, partial dentures, braces or bridgework, unless damaged or destroyed in a **covered accident**.

27. Treatment or services provided by the **covered person's immediate family**, except services rendered by a dentist.
28. Personal services, or comfort/convenience items such as television and telephone or transportation.
29. Orthopedic appliances used mainly to protect an injury.
30. Expenses payable by any automobile insurance **policy** without regard to fault.
31. Services or treatment provided by an infirmary operated by the **policyholder**.
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 for personal use.
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 an injury resulting from or contributed to by frostbite, fainting or seizures.
38. Any expenses in excess of **usual and reasonable charges** except as provided in this **certificate**.
39. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
40. 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.
41. Non-physical, occupational, speech therapies (art, dance, etc.).
42. Modifications made to dwellings.
43. General fitness, exercise programs.
44. Hypnosis.
45. Rolfing.
46. Biofeedback.
47. Use of electric, bio-mechanical devices.

BENEFIT SPECIFIC EXCLUSIONS

In addition to any general exclusions, benefits will not be paid for any **covered injury, covered loss** or **covered expense** which directly 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**:

Heart and Circulatory Conditions

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

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

CONDITIONS OF COVERAGE

Scope of Coverage

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

We will pay benefits provided by this **certificate**, subject to all applicable conditions and exclusions, when the **covered person** suffers a loss or incurs **covered expenses** resulting directly and independently 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 or off the location or premises of the **policyholder**:
 - a. During its normal hours when **school** is in session;
 - b. During the hours or on the days when the **policyholder's** regular classes are not in session and while the **covered person** is participating in or attending any **covered activities** ;
 - c. During scheduled functions; and
 - d. During other periods while the **covered person** is participating in a **sponsored, sanctioned and/or supervised activity** of the **policyholder**.
2. Attending or participating in a **sponsored, sanctioned and/or supervised activity** of the **policyholder** while away from the **policyholder** location or premises.
3. Attending or participating in one of the following **covered activities**:
 - a. Regularly-scheduled and approved practice session, drills, game or training;
 - b. Regularly-scheduled competition or exhibition game;
 - c. A scheduled tryout, workout session or team meeting;
 - d. Off-season training or conditioning program;
 - e. Covered sports travel.
4. Traveling directly, without interruption:
 - a. Between the **covered person's home** and the **policyholder** location or premises or the location of a **sponsored, sanctioned and/or supervised activity**; and/or
 - b. Between the site of the **sponsored, sanctioned and/or supervised activity** and the **covered person's home** or to the location or premises of the **covered activity**, if the **sponsored, sanctioned and/or supervised activity** is located within or outside the town where the **policyholder** is located including travel while participating in a **covered activity** that requires an overnight stay ; and/or
 - c. While on a **sponsored, sanctioned and/or supervised activity**, if the **sponsored, sanctioned and/or supervised activity** is located within the United States and the territories and possessions of the United States including travel while participating in a **covered activity** that requires an overnight stay; and/or
 - d. In a vehicle which is:
 - i. Designated or furnished by the **policyholder**;
 - ii. Operated by a properly licensed adult driver; or
 - iii. Under the direct supervision of the **policyholder**.

Definitions for the purposes of this coverage:

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

1. In which the **covered person** participates; and
2. Takes place at:
 - a. the **policyholder's** location or premises during scheduled hours; or
 - b. another site at which the **covered activity** is scheduled; and
3. Is organized and approved by the **policyholder**; and
4. Is supervised by a coach, referee or by another adult specifically assigned supervisory duties and authority for that **covered activity** by the **policyholder**; and
5. 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 Amount**.

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

Definitions:

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

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

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

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

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

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

Loss of Use of a Hand or Foot means total loss of all ability to move the hand or foot, within 90 days of a **covered accident**, that continues for 6 months and is expected to continue for the remainder of the **covered person's** lifetime.

Quadriplegia means total **paralysis** of both upper and lower limbs.

Paraplegia means total **paralysis** of both lower limbs or both upper limbs.

Hemiplegia means total **paralysis** of the upper and lower limbs on one side of the body.

Uniplegia means total **paralysis** of one upper or one lower limb.

Paralysis or Paralyzed means total loss of use. A **physician** must determine the loss of use to be complete and not reversible at the time the claim is submitted.

Total Paralysis means complete and irreversible loss of function and sensation of limbs.

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

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 **Accident Medical Expense Benefits**, the *General Exclusions and Benefit Specific Exclusion* Sections in order to understand all of the terms, conditions and limitations applicable to these benefits.

The covered injury must result 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 Accident 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 Accident Medical Benefit shown in the *schedule of benefits*. Benefits paid under this **certificate** will not exceed:

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

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

Benefits under this **certificate** will be reduced to the extent that benefits for **covered expenses** are covered by any **other health care plan**.

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

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

INPATIENT HOSPITAL SERVICES

Hospital Room and Board Expenses and miscellaneous services and supplies

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

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

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 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. 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 Surgical Services

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

Outpatient Hospital Non-Surgical Services

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

Emergency Room Expenses

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

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.

Surgeon Expenses

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

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

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

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

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

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

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

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

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

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

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

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

OUTPATIENT SERVICES AND SUPPLIES

Outpatient Physical Therapy

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

Outpatient Occupational and Speech Therapy

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

Nursing Services – Private Duty Nursing

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

Ambulance Services

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

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

Durable Medical Equipment and Orthopedic Braces and Appliances

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

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

Medical Services and Supplies

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

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

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

Prosthetic Devices 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**.

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.

OTHER BENEFITS

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**.

Expanded Medical Benefit for Sports Conditions

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

Heart and Circulatory Conditions

We will pay **covered expenses incurred** by the **covered person** for the treatment of a **heart or circulatory malfunction** if the **heart or circulatory malfunction** occurs and is first manifested during a **covered activity**.

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

Treatment of Hernia

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

Re-Aggravation of Prior Injury Benefits

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

For the purposes of this Re-aggravation of Prior Injury benefit only, such re-aggravation will be considered an "Injury" if the re-injury occurs under circumstances which would have otherwise been covered under this **certificate**.

CLAIM PROVISIONS

Notice of Claim

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

Claim Forms

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

Claimant Cooperation Provision

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

Proof of Loss

Written or authorized electronic proof of loss 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 the time required, no claim will be invalidated or reduced if it is shown that it was not reasonably possible to furnish notice within such time, provided such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than 1 year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity of the claimant.

Time of Payment of Claims

We will pay benefits due under this **certificate** for any loss, other than a loss for which this **certificate** provides any periodic payment, 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

Except benefits for loss of life, 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.

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

Appeals Procedure

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

Conformity with Statutes

Any provision in this **certificate** that is in conflict with the requirements of any state or federal law that apply to this **certificate** are automatically changed to 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 the **policy** may not be contested after it has been in force 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 **us** of any requirements of this **certificate** is not a continuing waiver of such requirements. Any failure by **us** to enforce any **certificate** provision will not be a waiver or amendment of that provision.

Non-Participating:

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

Certificate Changes

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

Workers' Compensation Insurance

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

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:

Texas Life and Health Insurance Guaranty Association
1717 West 6th Street, Suite 230
Austin, TX 78703-4776
1-800-982-6362 or www.txlifega.org

For questions about insurance, contact:

Texas Department of Insurance
P.O. Box 12030
Austin, TX 78711
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). **There may be other exceptions that aren't included in 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, “ we”, “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 compiled 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 ACCESSIBILITY 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 John Kelley Civil Rights Coordinator.

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

John Kelley Civil Rights Coordinator,
PO Box 15369
Springfield, MA 01115-5369
(413)-733-4612
Jkelley@wellfleetinsurance.com.

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance John Kelley of Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
800-8681019; 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.

مبينت: اذا تنك تحدثت **بغيركلا (Arabic)**، نإف تامدخ ةدعاسملا تيوغلا تينا جملا تحاتم لكلا. عاجرلا لاصتلاا ب (877) 657-5030.

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)**, udostępniłmy 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。

ی سراف امشد نابز رگا :مجموت (**Farsi**) دشادی م امشد رایتخا رد ن انگیار روط بی ی نابز دادما تامدخ ،تسا . (877) 657-5030 تمسا بیگرید .

कृपा ध्या दः यद आप हंद (Hindi) भाषी ह तो आपके लए भाषा सहायता सेवाएं: 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 yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjí' (877) 657-5030 hodílnih.

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

ગુજરાતી (Gujarati) યુ ના: જો તમે જરાતી બોલતા હો, તો િન:લુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છે. 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፣ በገጸ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደው(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, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ (877) 657-5030