The University of Texas System

# The University of Texas System Special Events

## Student Accident Insurance Plan

## 2026 - 2027

Policy Number: WI2021TXRISK84

The 2026-2027 Student Accident Insurance Plan is underwritten by Wellfleet.

Academic HealthPlans, Inc. (AHP), Part of the Brown & Brown Team, is an independent company that provides program management and administrative services for the student health plans of Wellfleet.

AHP-BRO(26) WF-UTSE

## Have a complaint or need help?

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

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

**WELLFLEET INSURANCE COMPANY**

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

**Call: Wellfleet Group, LLC at**
**Toll-free: (877) 657-5039**
Online:
https://www.wellfleetstudent.com/contact/
Email: appeals@wellfleetinsurance.com
Mail: P.O. Box 15769
Springfield, MA 01115

**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) 657-5039**

En línea: https://www.wellfleetstudent.com/contact/
Correo electrónico: appeals@wellfleetinsurance.com
Dirección postal:
P.O. Box 15769
Springfield, MA 01115

**El Departamento de Seguros de Texas**
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

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

# WELLFLEET INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

## BLANKET ACCIDENT INSURANCE POLICY

| | |
|---|---|
| **POLICYHOLDER:** | UNIVERSITY OF TEXAS SYSTEM SPECIAL EVENTS INSURANCE |
| **POLICY NUMBER:** | MP0000880161 |
| **POLICY EFFECTIVE DATE:** | August 1, 2026 |
| **POLICY TERM:** | August 1, 2026 through July 31, 2027 |
| **STATE OF ISSUE:** | Texas |

The **policy** is a legal contract between the **policyholder** and Wellfleet Insurance Company (herein referenced as "**we, us, our** and **company**").

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

**Policy Term**

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

This **policy** terminates at 11:59 P.M. on the **policy termination date**.

**Renewal**

With **our** consent, this **policy** can be renewed on each Policy Anniversary date for future terms by the payment of **premium** due at the rates agreed upon for each such renewal. If the **policy** is not renewed, insurance will terminate as of the date the last **policy term** ends. Coverage may be terminated in accordance with the Termination provision of this **policy**.

Subject to the terms and conditions of this **policy**, it can be renewed upon the first rate guarantee date by timely payment of the required **premium**. Unless terminated in accordance with the applicable provisions of this **policy**, it can be renewed after such time from month to month by timely payment of the required **premium**.

**Premium due dates**

**Premium** is due on the date set by **us**.

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

**Right to examine this policy**

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

**THIS IS NOT A WORKERS' COMPENSATION POLICY AND IS NOT A SUBSTITUTE FOR WORKERS' COMPENSATION COVERAGE.**

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

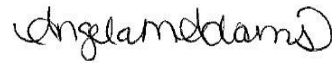
**THIS POLICY CONTAINS A DEDUCTIBLE**

**PLEASE READ THIS POLICY CAREFULLY**
**NON-PARTICIPATING**

**THIS COVERAGE MAY BE SUBJECT TO A PREMIUM INCREASE AT THE TIME OF RENEWAL OR TO NONRENEWAL AS OUTLINED IN THIS POLICY.**

This **policy** is executed for the **company** by its President and Secretary:

Andrew M. DiGiorgio, President



Angela Adams, Secretary

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## Policyholder Questions or Comments

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

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

Please have **your policy** number available when **you** contact **us**. It is on the front page of this **policy**.

Underwritten by Wellfleet Insurance Company
Administrator:
Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369
877-657-5039

## Definitions

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

### Covered Activity

An activity or event that takes place under one of the conditions of coverage specified in the Conditions of Coverage section of the **certificate,** in which Classes of Covered Persons as shown in the **certificate** are provided insurance under this **policy**.

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

### Covered Member

A member of the **policyholder** who is eligible and insured for coverage under this **policy**.

### Covered Person

A **covered member** for whom all of the following applies:

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

### Dates:

#### Effective Date

The date coverage becomes effective.

#### Premium Due Date

**Premium** is due on the date set by the **company**.

#### Termination Date

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

### Policy Term

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

### Policyholder

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

### Premium

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

### Policy

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

## Premium

### Premium Rates

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

## Premium Payment

The total **premium** paid by **you** is the sum of **premiums** for all **covered persons**, unless **you** and **we** agree to another mode of **premium** payment. **Premiums** are paid at **our** home office or to **our** authorized agent.

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

## Grace Period

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

1. **We** do not intend to renew this **policy** beyond the period for which **premium** has been accepted; and
2. written notice of **our** intention not to renew is delivered to **you** at least 31 days before the **premium** is due.

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

## Premium Rate Changes

**We** may change **premium** rates at the end of any **policy term** with at least 60 days advance notice mailed to **your** last known address. **We** will not increase **premium** rates more frequently than annually, unless one of the events described below occurs.

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

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

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

## Premium – Eligibility Corrections

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

# Final rates

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

# Termination

## Automatic Termination

This **policy** and all coverage will end as of the last day of the **policy** Grace Period if **you** have not paid **us** all **premiums** as of the end of the **policy** Grace Period.

## Termination by You

**You** may end coverage under this **policy** if **you** give **us** 31 days advance written notice. The advance written notice must include the **termination date**. The **termination date** shall not be earlier than 31 days after the date of the notice unless **you** and **we** agree. **Your** termination notice may apply to all classes, or any class of **covered persons** covered under this **policy**. **You** can send **us** a termination notice during a period for which **you** have paid **premium**, but **your termination date** must be after that period.

## Termination by Us

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

1. Immediately upon written notice to **you** if **you** perform any act or practice that constitutes fraud or if **you** make any intentional misrepresentation of a material fact relevant to the coverage.
2. At any time after the end of the **policy** Grace Period if **you** have not paid the **premium**. **We** will give **you** written notice of the **termination date**.
3. Upon 60 days written notice to **you**:
   a. If **you** breach a provision of the **policy** and **you** do not cure the breach within the notice period.
   b. If **you** cease to be an eligible blanket accident insurance **policyholder** as defined under applicable law.
   c. If **you** change **your** eligibility or participation requirements without **our** consent.

## Effect of Termination

**You** and **we** continue to be responsible following termination for the duties **you** and **we** each incurred prior to the termination of this **policy**. One of **your** duties includes payment of **premium** due for coverage through any **policy** Grace Period up to the day of termination. **You** and **we** also continue to be responsible for **your** and **our** duties that this **policy** states are to occur following termination.

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

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

## Notices – Termination of Coverage

**You** shall notify **covered persons** in writing of their rights when coverage stops.

## Reinstatement

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

# Administration Provisions

## Indemnification

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

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

## Certificates

Where required by law, **we** will provide a **certificate** to **you** for delivery to the **covered person.** Each **certificate** will set forth a statement as to the insurance coverage to which the **covered person** is entitled, and to whom the insurance benefits are payable.

### Distribution – Certificate and Other Materials

**We**, or **you,** will distribute to the **covered person** as required by applicable federal and state laws, the **certificate** and other materials relating to enrollment and coverage features that **we** provide to **you**.

## General Provisions

### Applicable Law

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

### Conformity with Law

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

### Entire Contract

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

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

These documents are the entire contract between **us** and **you**.

All **certificate** documents that are part of the complete **policy** are on file with **us** and **you**. All statements made by **you** will be treated as representations and not warrantees.

### Changes to the Policy

This **policy**, including the application, endorsements, amendments and any attached papers constitutes the entire contract of insurance.

No change in this **policy** will be valid until approved by one of **our** executive officers and endorsed on or attached to this **policy**. No agent has authority to change this **policy** or to waive any of its provisions. **We** may agree with **you** to modify a plan of benefits without the **covered person's** consent.

### Statement Made by Policyholder or Covered Person

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

### Legal Actions

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

## Clerical Error

A **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 **policy**. If such error or delay is found, **we** will adjust the **premium** fairly.

## Misstatement of Material Fact

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

## Noncompliance with Policy Requirements

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

## Discrimination Prohibited

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

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

## Financial Sanctions Exclusion

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

## Incontestability

The validity of this **policy** may not be contested after it has been in 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, after the insurance has been in force before the contest for two years during the individual's lifetime and unless the statement is contained in a written instrument signed by the individual making the statement.

## Records

**You** or **your** authorized administrator will maintain the records of the **covered person's** insurance under this **policy**. **We** will be permitted to examine **your** records relating to the insurance under this **policy** at any reasonable time. **You** are acting as an agent of the **covered person** for transactions relating to this insurance. **Your** actions will not be considered **our** actions.

## Reporting Requirements

**You** or **your** authorized agent must report all of the following to **us** by the **premium due date**:

1. The names of all persons insured on this **policy effective date**;
2. The names of all persons who are insured after the **policy effective date**;
3. The names of those persons whose insurance has terminated;
4. Additional information required by **us**.

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

## Non-Participating

This **policy** is non-participating. It does not share in **our** profits or surplus earnings.

## Notices

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

Notice may be delivered:

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

**Notice sent to us by mail and commercial carrier shall be sent to:**
Wellfleet Insurance Company
c/o Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369

**Notice sent to you by mail and commercial carrier shall be sent to the address that we have on file for you or your authorized agent.**

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

## Privacy

**We** will protect the personal health information of **covered persons** as required by federal and state laws. **We** will use it and share it with others as needed for their care and treatment. **We** will also use and share it to help **us** process provider's claims and otherwise help **us** administer this **policy**. For a copy of **our** Notice of Privacy Practices, visit **our** website at www.wellfleetinsurance.com.

## Policies and Procedures

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

## Third Parties Rights

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

## Workers' Compensation Insurance

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

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

# WELLFLEET INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

## BLANKET ACCIDENT INSURANCE CERTIFICATE

| | |
|---|---|
| **POLICYHOLDER:** | UNIVERSITY OF TEXAS SYSTEM SPECIAL EVENTS INSURANCE |
| **POLICY NUMBER:** | MP0000880161 |
| **POLICY EFFECTIVE DATE:** | August 1, 2026 |
| **POLICY TERM:** | August 1, 2026 through July 31, 2027 |
| **STATE OF ISSUE:** | Texas |

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 NOT A WORKERS' COMPENSATION POLICY AND IS NOT A SUBSTITUTE FOR WORKERS' COMPENSATION COVERAGE.**

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

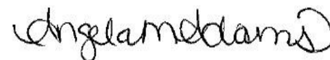
**THIS CERTIFICATE CONTAINS A DEDUCTIBLE**

**PLEASE READ THIS CERTIFICATE CAREFULLY**

**NON-PARTICIPATING**

**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 coverages and benefits provided by this certificate. Please read the Conditions of Coverage section and each benefit description section for full details.**

**CLASSES OF COVERED PERSONS:**

| **Eligible Class(es) of Covered Persons** | **Description of Class(es)** |
|---|---|
| **Class 1** | All enrolled participants as defined by the **Policyholder** while engaged in a **Covered Activity** sponsored and supervised by the **Policyholder**. |

**COVERED ACTIVITIES:**

| | |
|---|---|
| **Class 1** | All activities sponsored and supervised by the **Policyholder**, including travel to and from policyholder sponsored activities. |

| **ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS** | |
|---|---|
| **Principal Sum**<br>Accidental Death<br>Accidental Dismemberment | $50,000 |
| **Covered Loss** must occur within | 365 days of the **covered accident** |
| **Accidental Death and Dismemberment Aggregate Limit** | $1,000,000 |
| **SCHEDULE OF COVERED LOSSES** | |
| **Covered Loss** | **Benefit** |
| Loss of Life | **Principal sum** |
| Loss of Both Hands or Both Feet | **Principal sum** |
| Loss of One Hand and One Foot | **Principal sum** |
| **Loss of Sight** of Both Eyes | **Principal sum** |
| Loss of One Hand or foot and Sight of One Eye | 100% of **principal sum** |
| Loss of One Hand or One Foot | 100% of **principal sum** |
| Loss of Thumb and Index Finger of the Same Hand | 100% 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 | 10% 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** | 200% of **principal sum** |
| **Paraplegia** | 100% of **principal sum** |
| **Hemiplegia** | 100% of **principal sum** |
| **Uniplegia** | 50% of **principal sum** |
| **Brain Death**<br>**Brain Death** must occur within 90 days of a **covered accident**. | **Principal sum** |
| **Coma Benefit**<br>**Coma** must begin within 180 days of a **covered accident** and continue for at least 31 consecutive days. | **Principal sum** |
| **Exposure and Disappearance Coverage** | |
| Benefit Limit | **Principal sum** |

## ADDITIONAL ACCIDENT INDEMNITY BENEFITS

**Any benefits payable under the Additional Accident Indemnity Benefits shown below are in addition to any other benefits payable under this certificate.**

| **CRISIS DEATH BENEFIT** | |
|---|---|
| Benefit Limit per **covered person** | $25,000 |
| **Aggregate Limit** | $100,000 |

## 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 customary charges.**

| **SCOPE OF COVERAGE APPLICABLE TO ACCIDENT MEDICAL BENEFITS** | |
|---|---|
| Full Excess Accident Medical Maximum | $100,000 per **covered accident** |
| **Accident** Medical **Coinsurance** | 100% of **usual and customary charges (U&C)** |
| Individual **disappearing** Medical **deductible** | $50 per **covered accident** |
| **Benefit Period**<br>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:<br>• 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** |
| **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 and 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 |

## 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.

**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**.

**Brain Death** means irreversible unconsciousness, resulting directly and independently of all other causes from a **covered accident** within the time period shown in the Schedule of Benefits manifested by both total loss of brain function and complete absence of electrical activity of the brain, even though the heart is still beating and diagnosed by a **physician**.

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

**Coinsurance** means the percentage of **usual and customary 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.

**Coma** means a state of unconsciousness from which the **covered person** is not likely to be aroused through powerful stimulation. The **coma** must begin within the time period shown in the Schedule of Benefits for the **covered accident**, continue for the time period shown in the Schedule of Benefits and must be diagnosed and treated regularly by a **physician**. **Coma** does not mean any state of unconsciousness intentionally induced during the course of treatment of a **covered injury** unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of injuries sustained in that **covered accident**. **We** will terminate benefits if **physician** certification of **coma** or **total disability** is not provided when requested.

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

**Covered Accident** means a sudden, unforeseeable, external event that results, directly and independently of all other causes, in a **covered injury** or **covered loss** and meets all the following conditions:
1. Occurs while the **covered person** is insured under this **certificate**;
2. Is not contributed to by disease, **sickness**, or mental or bodily infirmity; and
3. Is not otherwise excluded under the terms of this **certificate**.

**Covered Activity** means those activities or events set out in the **covered activities** section of the Schedule of Benefits, in which classes of **covered persons** are provided insurance under this **certificate**.

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

**Covered Expenses** means the **usual and customary charges** for treatment, services, or supplies listed in the Schedule of Benefits, and described in the **Accident Medical Benefits** section, that the **covered person incurred** for **medically necessary** treatment of a **covered loss**. 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**.

**Covered Loss or Covered Losses** means an accidental death, dismemberment or other injury covered under this **certificate**.

**Covered Member** means a member of the **policyholder** who is eligible and insured for coverage under this **certificate**.

**Covered Person** means a **covered member** 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.

**Emergency Care** means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in

1. placing the patient's health in serious jeopardy
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

**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 someone 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**, former **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, or aunt, uncle, cousins, grandparents, or grandchild.

**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**.

**Maximum Amount** means the amount payable for each **covered person** within a **policy term** as shown in the Schedule of Benefits.

**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:

1. Standards that are based on credible scientific evidence published in peer-reviewed, medical literature generally recognized by the relevant medical community;
2. **Physician** and health care provider specialty society documents;
3. The views of **physicians** and health care providers practicing in the relevant clinical areas; and
4. 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. A person living in the **covered person'**s household; or
3. 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.

**Personal Deviation** means (1) non-business travel or activities undertaken while traveling to and from an activity which is covered under this **certificate.**

**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, including a doctor of osteopathic medicine 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. A person living in the **covered person'**s household;

3. A person employed or retained by the **policyholder;** or
4. 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** means the amount payable for each **covered person** within a **policy term** 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 or employed. The **school** must be licensed or accredited, as applicable, by the jurisdiction where it is located, to provide the care, education or training for which the **covered person** is enrolled.

**Sickness** means a physical or mental illness, including pregnancy.

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

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

**Total Disability or Totally Disabled** means:
1. The complete inability of the **covered person** to perform all of the substantial and material duties and functions of the **covered person's** occupation and the **employee** is unable to perform any other gainful occupation in which the **employee** earns substantially the same compensation earned before the disability, and
2. with respect to any other **covered person**, confinement as a bed patient in a **hospital**.

To be considered **totally disabled**, a **physician** must certify that a **total disability** is expected to continue for the **covered person's** lifetime.

**Usual and Customary Charge** (**U&C**) means the common charge made or accepted for medical services, care, or supplies that are eligible for coverage under this **certificate**. The **covered person** is responsible for all amounts above what is eligible for coverage.

The **usual and customary charge** depends on the geographic area where the **covered person** receives the medical services, care, or supplies.

The **usual and customary charge** is determined based upon:
1. The amount of resources expended to deliver the treatment;
2. The complexity of the treatment rendered; and
3. Charging protocols and billing practices generally accepted by the medical community.

For Accident Medical Benefits, the table below shows the method for calculating the **usual and customary charge** for specific services or supplies:

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

Special terms used
- Geographic area is normally based on the first 3 digits of the U.S. Postal Service zip codes. If **we** determine **we** need more data for a particular service or supply, **we** may base rates on a wider geographic area such as an entire state.
- "Reasonable amount rate" means the **covered person's** plan has established a reasonable rate amount as follows:

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

**Our** reimbursement policies:
**We** reserve the right to apply **our** reimbursement policies to all services including involuntary services. **Our** reimbursement policies may affect the **usual and customary charge**. These policies consider:
- The duration and complexity of a service.
- When multiple procedures are billed at the same time, whether additional overhead is required.
- Whether an assistant surgeon is necessary for the service.
- If follow-up care is included.
- Whether other characteristics modify or make a particular service unique.
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided.

- The educational level, licensure or length of training of the provider.

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

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

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

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

**War** means a state or period of declared or undeclared **war** whether civil or international, any substantial armed conflict with organized forces of a military nature between nations, states or parties. Terrorism is not considered an act of **war**.

## 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 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.

**We** maintain the right to investigate eligibility status and attendance records to verify that eligibility requirements have been and continue to be met. If **we** discover the eligibility requirements have not been met, **our** only obligation is refund of premium. Eligibility requirements must be met each time premium is paid to continue coverage.

### Effective Date of Insurance

Insurance becomes effective for the **covered member** on the latest of the following dates:

1. The **policy** Effective Date; or
2. The date the person becomes eligible

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

**Effective Date of Changes**
Any increase or decrease in the amount of insurance for the **covered person** resulting from a change in benefits provided by this **certificate** or a change in the **covered person's** eligibility (as set forth under **Eligible Class(es) of Covered Persons** in the Schedule of Benefits) will take effect on the date of such change.

### Termination Date of Insurance

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

1. The date the **covered member** is no longer in an Eligible Class; or
2. The date the **covered member** enters full time active duty in any Armed Forces. **We** will refund any premium paid for any period of active duty when **we** receive proof of active duty. Active duty does not include Reserve or National Guard duty for training; or
3. The end of the period for which the last premium is made; or
4. The date coverage for the Eligible Class of which the **covered member** is a member ends; or
5. The date this **certificate** ends

**Extension Of Benefits**
**We** will extend benefits under the certificate if the **covered person** is **total disabled** or Confined on the date the Policy terminates or is discontinued. Coverage will continue until the earliest of the end of the 90-day period following the date the Policy terminates or is discontinued or the date the **covered person** is no longer **totally disabled** or confined.

Any benefits payable under this provision will not exceed the benefit maximums shown in the **schedule of benefits**

## CONDITIONS OF COVERAGE

## Scope of Coverage

This section describes the Scope of Coverage under which benefits provided by this **certificate** become payable when a **covered person** suffers a **covered loss** or **covered injury** as a result of a **covered accident**. Any benefits are payable only once, even though more than one Scope of Coverage may apply. Please read these and the General Exclusions 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 of all other causes from a **covered accident** that occurs while participating in a **policyholder sponsored, sanctioned and/or supervised covered activity** named in the Schedule of Benefits.

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

The **covered person** must be:

1. On the location or premises of the **policyholder**:
    a. During scheduled functions; and
    b. During other periods while the **covered person** is participating in a **sponsored, sanctioned and/or supervised activity** of the **policyholder**.
2. Attending or participating in a **sponsored, sanctioned and/or supervised activity** of the **policyholder** while away from the **policyholder** location or premises.
3. Traveling directly, without interruption:
    a. Between the **covered person's home** and the **policyholder** location or premises or the location of a **sponsored, sanctioned and/or supervised activity**; and/or
    b. 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:

**Travel Time** means the time:

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

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

1. In which the **covered person** participates; 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 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 Section in order to understand all of the terms, conditions and limitations of coverage.

### ACCIDENTAL DEATH AND 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**.

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**.

**Definitions**

**For purposes of this Benefit:**

**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.

**Exposure And Disappearance Coverage**

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

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

## ADDITIONAL ACCIDENT INDEMNITY BENEFITS

### CRISIS DEATH BENEFIT

**We** will pay the benefit amount shown on the Schedule of Benefits if the **covered person's** death results, directly and independently of all other causes, from another person's use of a gun or a knife to commit an act of violence while the **covered person's** coverage under this **certificate** is in effect. Such act of violence must occur during a **covered activity.**

For the purposes of this benefit, **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**, excluding travel; 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.

We will not pay the benefit if:

1. the act of violence is committed by an **immediate family member**; or
2. the **covered person** produces or obtains a gun or knife during the **covered activity** and is killed, whether or not the **covered person** is acting in self-defense.

Not more than the **aggregate limit** shown in the Schedule of Benefits will be paid if more than one **covered person's** death results from the same act of violence. The **aggregate limit** will be divided equally among all **covered persons** if the benefit payable for each **covered person** multiplied by the number of benefits payable for the same act of violence would exceed that limit.

# 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 and the General Exclusions 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 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 **inpatient hospital stay**;
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 <u>separate operative fields</u>. When this happens, **we** will pay:
   - 100% of the surgery for the primary procedures
   - 50% of the surgery for the secondary procedure
   - 25% of 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
  - o The first **hospital** cannot provide the emergency services the **covered person** needs
  - o 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 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, coinsurance consistent with annual deductibles, and coinsurance required for other coverage and may not be subject to annual dollar limits. Subject to 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**, and **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 **covered 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 **covered 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 **covered person**, 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 **covered 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.**

## 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. **Personal deviations** are not covered.
4. Declared or undeclared **war** or act of **war**.
5. Commission or attempt to commit a felony or an assault.
6. Commission of or active participation in a riot or insurrection.
7. Flight in, boarding or alighting from an **aircraft** Optional, i.e.: Or any craft designed to fly above the Earth's surface, except as a fare-paying passenger on a regularly scheduled commercial or charter airline. This includes:
   a. A passenger in a non-scheduled, private **aircraft** used for pleasure purposes with no commercial intent during the flight;
   b. An ultra-light or glider;
8. Travel in or on any on-road and off-road motorized vehicle except a golf cart or other vehicle **we** specifically agree to cover, that does not require licensing as a motor vehicle.
9. 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.
10. **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.
11. Travel or activity outside the United States and the territories and possessions of the United States, Canada or Mexico.
12. **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.
13. 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.
14. Treatment in any Veteran's Administration, Federal, or state facility, unless there is a legal obligation to pay.

15. 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**.
16. Hearing aids, or purchase, repair or replacement of, except due to a **covered accident** as described elsewhere in this **certificate**.
17. Wheelchairs, braces, appliances, orthopedic braces, or orthotic devices except due to a covered accident as described elsewhere in this **certificate**.
18. 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.
19. Rest cures, long-term care or custodial care.
20. 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**.
21. 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.
22. Services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay.
23. Treatment or services provided by the **covered person's immediate family** except services provided by a dentist.
24. Personal services, or comfort/convenience items such as television and telephone or transportation.
25. Expenses payable by any **automobile** insurance **policy** without regard to fault.
26. Services or treatment provided by an infirmary operated by the **policyholder**.
27. Treatment of injuries that result over a period of time (such as blisters, tennis elbow, etc.), and that are a normal, foreseeable result of participation in the **covered activity**.
28. Treatment or service provided by a private duty **nurse** except due to a **covered accident** as described elsewhere in this **certificate**.
29. Charges for hot or cold packs for personal use.
30. Custodial Care service and supplies.
31. Expenses that are not recommended and approved by a **physician**.
32. Repair or replacement of existing artificial limbs, eyes and larynx, unless damaged or destroyed in a **covered accident**.
33. Participation in any sports activity not specifically authorized, sponsored and supervised by the **policyholder**, whether or not it takes place on **policyholder** premises.
34. Any expenses in excess of **usual and customary charges** except as provided in this **certificate**.
35. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
36. Non-physical, occupational, speech therapies (art, dance, etc.).
37. Modifications made to dwellings.
38. General fitness, exercise programs.
39. Hypnosis.
40. Rolfing.
41. Biofeedback.
42. Use of electric, bio-mechanical devices.

## 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. 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 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 the covered person or to the covered person's designee.

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.

**Texas Health and Human Services Commission** In the event that the Texas Health and Human Services Commission is paying benefits on behalf of a **covered person**, **we** will pay benefits under the Policy for the **covered person** to the Texas Health and Human Services Commission if:

1. The parent who is a **covered person** is required to pay child support by a court order or court-approved agreement and is not a possessory conservator of the **covered person's** dependent **child** under a court order issued in Texas or is not entitled to possession of or access to the **covered person's** dependent **child**.
2. The Texas Health and Human Services Commission is paying benefits on behalf of the **covered person's** dependent **child;** and
3. **We** are notified, through an attachment the notice of claim at the time the notice of claim is first submitted to **us,** that the benefits must be paid directly to the Texas Health and Human Services Commission.

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

**Written request shall be sent to:**

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

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

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

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

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

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

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

**Legal Actions**
No action at law or in equity will be brought to recover benefits under this **certificate** less than 60 days after 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 applies 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, after the insurance has been in force before the contest for two years during the individual's lifetime and unless the statement is contained in a written instrument signed by the individual making the statement.

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

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

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

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

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

## HIPAA Notice of Privacy Practices

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

## PLEASE REVIEW IT CAREFULLY

Effective: August 01, 2019

This Notice of Privacy Practices ("Notice") applies to **Wellfleet Insurance Company** and **Wellfleet New York Insurance Company**'s (together, "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 complied in reasonable anticipation, or for use in, a civil, criminal or administrative action or proceeding;
- Health Information that is subject to a law prohibiting access to that information; or,
- If the Health Information was obtained from someone other than us under a promise of confidentiality and the access request would be reasonably likely to reveal the source of the information.

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

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

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

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

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

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

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

**CONTACT**

For all inquiries, requests and complaints, please contact:

Privacy and Security Officer
Wellfleet Insurance Company/
Wellfleet New York Insurance Company
c/o Wellfleet Group, LLC
PO Box 15769
Springfield, MA 01115-5769

In California
c/o Wellfleet Group, LLC
dba Wellfleet Administrators, LLC
PO Box 15769
Springfield, MA 01115-5769

**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 15769
Springfield, MA 01115-5769

In California
c/o Wellfleet Group, LLC
dba Wellfleet Administrators, LLC
PO Box 15769
Springfield, MA 01115-5769

## NOTICE OF NON-DISCRIMINATION AND ACCESSIBIILITY REQUIREMENTS

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

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

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

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

1. Interpreters
2. information translated into other languages

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

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

Civil Rights Coordinator,
PO Box 15769
Springfield, MA 01115-5769
(413) 733-4540
civilcoordinator@wellfleetinsurance.com

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

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

# ADVISORY NOTICE TO POLICYHOLDERS

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

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

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

OFAC of the U.S. Department of Treasury administers and enforces economic and trade sanctions policy on Presidential declarations of "National Emergency". OFAC has identified and listed numerous:

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

as *Specially Designated Nationals* and *Blocked Persons.* This list can be found on the U.S. Department of Treasury's website (www.treas.gov/ofac)

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

# LANGUAGE ASSISTANCE PROGRAM

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call (877) 657-5039.

ATENCIÓN: Si habla **español (Spanish)** , hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al (877) 657-5039.

請注意：如果您說中文 **(Chinese)** 我們免費為您提供語協助服務。請致電 (877) 657-5039.

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) 657-5039.

알림: 한국어**(Korean)** 를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. (877) 657-5039. 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)** , may makukuha kang mga libreng serbisyo ng tulong sawika. Mangyaring tumawag sa (877) 657-5039.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является**русс ком (Russian)** . Позвоните по номеру (877) 657-5039.

ةيبرعلااذإ: هيبنت ثدحتت تنك - (**Arabic**) اجرلا .كل ةحاتم ةيناجملا ةيوغللا ةدعاسملا تامدخ نإف ءب لاصتلأا ، (877) 657 5039.

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) 657-5039.

ATTENTION : Si vous parlez **français (French)** , des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le (877) 657-5039.

UWAGA: Jeżeli mówisz po **polsku (Polish)** , udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer (877) 657-5039.

ATENÇÃO: Se você fala **português (Portuguese)** , contate o serviço de assistência de idiomas gratuito. Ligue para (877) 657-5039.

ATTENZIONE: in caso la lingua parlata sia l' **italiano (Italian)** , sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero (877) 657-5039.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie (877) 657-5039 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) 657-5039 にお電話ください。

هجوت: رگا نابز امش سامت دیریگب. **یسراف (Farsi)** ، تامدخ دادما ینابز هب روط ناگیار رد رایتخا امش یم دشاب تسا (877) 657-5039.

कृपया ध्यान दें: यदि आप हिंदी (**Hindi**) बोलते हैं, तो भाषा सहायता सेवाएँ आपके लिए निःशुल्क उपलब्ध हैं। कृपया (877) 657-5039 पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau (877) 657-5039.

ប្រយ័ត្ន៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ (**Khmer**) សេវាជំនួយភាសា គឺមិនគិតថ្លៃទេ អាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅ (877) 657-5039.

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) 657-5039.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' (877) 657-5039 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac (877) 657-5039.

**ગુજરાતી (Gujarati)** ચુ ના: જો તમે જરાતી બોલતા હો, તો િ◌ન:લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો (877) 657-5039.

**λληνικά (Greek)**ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξη ς, οι οποίες παρέχονται δωρεάν. Καλέστε (877) 657-5039.

Українська (**Ukrainian**) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безко штовної служби мовної підтримки. Телефонуйте за номером (877) 657-5039.

አማርኛ (**Amharic**) ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ(877) 657-5039.

ਪੰਜਾਬੀ (**Punjabi**): ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ, ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ (877) 657-5039 'ਤੇ ਕਾਲ ਕਰੋ।

**ພາສາລາວ (Lao**) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້ າພາສາ ລາວ, ການບໍ ລິ ການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ ເສັ ຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (877) 657-5039.

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

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

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

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

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

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

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

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

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

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

| To learn more about the Association and your protections, contact: | For questions about insurance, contact: |
|---|---|
| **Texas Life and Health Insurance Guaranty Association**<br>1717 West 6th Street, Suite 230<br>Austin, TX 78703-4776<br>1-800-982-6362 or www.txlifega.org | **Texas Department of Insurance**<br>P.O. Box 12030<br>Austin, TX 78711<br>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.

WELLFLEET
SPECIAL RISK

PO Box 15369
Springfield, MA 01115-5369
(877) 657-5039
specialriskCS@wellfleetinsurance.com
fax: (413) 733-4612

**PLEASE FULLY COMPLETE THIS FORM**

**ATTACH ITEMIZED BILLS**

**MAIL ALL INFORMATION TO THE ABOVE ADDRESS**

## PART I – POLICYHOLDER'S REPORT

| Participating Group Number: SR513292PA | Policyholder Number: MP0000880161 | Policyholder Name: UNIVERSITY OF TEXAS SYSTEM SPECIAL EVENTS INSURANCE | | |
|---|---|---|---|---|
| Claimant's Name (Injured Person) | E-Mail Address | Gender ☐ M ☐ F | Date of Birth | Event, Activity or Sport |

Address of Injured Person and Best Contact Phone Number (Include Area Code) (   )

Address | City | State | Zip Code

| Date and Time of Accident | Place where Accident Occurred | The injured person was a: ☐ Particpant ☐ Staff Member ☐ Other |
|---|---|---|
| Dental Claim | Indicate which Teeth were Involved in the Accident | Describe Condition of Injured Teeth Prior to Accident: ☐ Whole, Sound & Natural ☐ Filled ☐ Capped ☐ Artificial |

Type of Injury (Indicate Part of Body Injured and left or right side– e.g. broken arm, sprained ankle, etc.)

Did Injury Result in Death? ☐ Yes ☐ No

Describe How Accident Occurred – Give All Possible Details

Did Accident Occur (Check Yes or No for Each of the Following):

A. During a policyholder programmed, sponsored & supervised, or sanctioned activity? ☐ Yes ☐ No

B. On activity premises? ☐ Yes ☐ No

C. While traveling directly and uninterruptedly to or from the event? ☐ Yes ☐ No

D. During intercollegiate/scholastic athletic practice or competition? ☐ Yes ☐ No

I certify that the above information is correct to the best of my knowledge and belief, that the person named above is insured by the policy, and that his or her insurance was in effect on the date the accident occurred.

| Signature of Plan Sponsor | Name, Title and Telephone Number of Plan Sponsor | Date |
|---|---|---|
| | | |

## PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or are you enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through an employer, a parent's employer or other source?

☐ Yes ☐ No

If yes name of insurance company: ______________________________ Policy #: ______________________________________________________

Other Insurance Carrier ID# ___________________________________ Other Insurance Carrier Telephone# ______________________________

Mother's (Guardian's) primary employer name, address & telephone: _______________________________________________________

Father's (Guardian's) primary employer name, address & telephone: _________________________________________________________

Are you eligible to receive benefits under any governmental plan or program, including Medicare?

☐ Yes ☐ No If yes, please explain: __________________________________________________________________________

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.

I agree that should it be determined at a later date there is another insurance (or similar), to reimburse Wellfleet Group to the extent of any amount collectible.

SIGNATURE _________________________________________________ DATE ___________________________________

## PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. If not signed, please provide proof of payment.

SIGNATURE ___________________________________________________ DATE ___________________________________

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates or information concerning the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records or all such records in their entirety to Wellfleet Group, LLC. A photo static copy of this authorization shall be considered as effective and valid as the original.

I agree that should it be determined at a later date there is other insurance (or similar), to reimburse Wellfleet Group to the extent of any amount collectible.

I certify that the above information is correct to the best of my knowledge and belief. I understand that any person who knowingly and with the intent to defraud or deceive any
insurance company; files a claim containing any material by false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNATURE _________________________________________________ DATE __________________________________

# FRAUD STATEMENTS

## Important Notice

- ***In General, and specifically for residents of Arkansas, Louisiana, Rhode Island and West Virginia:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

- ***For residents of Colorado:*** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

- ***For residents of the District of Columbia:*** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

- ***For residents of Florida:*** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

- ***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

- ***For residents of Maine, Tennessee, Virginia and Washington:*** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

- ***For residents of Oregon:*** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

- ***For residents of Maryland:*** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

- ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

- ***For residents of New Mexico:*** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

- ***For residents of New York:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

- ***For residents of Ohio:*** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

- ***For residents of Oklahoma:*** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

- ***For residents of Pennsylvania:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.