WELLFLEET INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

THIS IS A LIMITED BENEFIT HEALTH COVERAGE POLICY AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

APPLICATION FOR PARTICIPANT ACCIDENT INSURANCE

1. Name of Policyholder: Association Resource Group
2. Mailing Address: 13790 E. Rice Place, Suite 100 Aurora, CO 80015
3. Policy Number: MP0000859940
4. Policy Effective Date: January 1, 2025 Policy Term Date: December 31, 2025

5. **Plan of Benefits:**

Accidental Death and Dismemberment Benefit Class 1

Accidental Death: $40,000
Accidental Dismemberment: $40,000
Paralysis Benefits included ☐ Loss of Use Benefits included ☐
AD&D Aggregate Limit: $1,000,000
Exposure & Disappearance Coverage included: ☐ Yes ☒No

Accidental Death and Dismemberment Benefit Class 2

Accidental Death: $5,000
Accidental Dismemberment: $5,000
Paralysis Benefits included ☐ Loss of Use Benefits included ☐
AD&D Aggregate Limit: $1,000,000
Exposure & Disappearance Coverage included: ☐ Yes ☒No

Accident Medical Benefits Class 1 & Class 2

Accident Medical Maximum: $10,000
Accident Medical Coinsurance: 100%
Individual Disappearing Medical Deductible: $100
Benefit Period: 52 weeks from date of covered accident
Treatment Window: 180 days

Additional Accidental Indemnity Benefits

Total Disability Weekly Income Benefit

Benefit Period: 53 weeks

Weekly Disability Benefit: $200 for weeks 1-52, then $40,000 lump sum for week 53.

6. **Plan Type:**
Full Excess Medical

7. **CLASSIFICATION TABLE**

Class	Eligible Class(es) of Covered Persons – Description of Class
1	All Club Members, Voluntary Helpers and Officials over the age of 18, including Stewards, Gatemen, Doctors, Veterinary Surgeons and the like, and all paid helpers over the age of 18, under the supervision or control of the Policyholder, excluding any employees paid by any person or entity under written contract to the Policyholder.

2	All Club Members, Voluntary Helpers and Officials between the ages of 12 to 18, including Stewards, Gatemen, Doctors, Veterinary Surgeons, and the like, and all paid helpers between the ages of 12 to 18, under the supervision or control of the Policyholder, excluding any employees paid by any person or entity under written contract to the Policyholder.

8. **Covered Activities (please specify):** Participation in the following Policyholder supervised and sponsored activities: Club sponsored and supervised events. Overnight supervised and sponsored activities with duration of more than 7 days and related travel are not covered unless specifically agreed to in writing by the carrier.

Covered travel included travel in the United States, its territories and possessions, Puerto Rico and Canada. This Coverage will not be in effect during travel to and Covered Activity that takes place outside of the United States, its territories and possessions, Puerto Rico and Canada, unless We have agreed to provide it in writing in advance.

9. **PREMIUM REPORT**

Standard Premium Rate	**$50** per club per year by **monthly audits**
Total Premium Due	**$**
Minimum Policy Premium	**$500.00**

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

WARNING: 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.

Signature of Policyholder | President (Position or Title) | 12/27/24 (Date)

Check if no agent is used: ☐
Agent/Broker Name:
Address:
Phone Number:
Email Address:
Tax I.D: -

Signature of Agent/Broker | 12/27/2024 (Date)

WELLFLEET INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

BLANKET ACCIDENT INSURANCE POLICY

POLICYHOLDER:	ASSOCIATION RESOURCE GROUP (**Policyholder**, You, or Your)
POLICY NUMBER:	MP0000859940
POLICY EFFECTIVE DATE:	January 1, 2025
POLICY TERMINATION DATE:	December 31, 2025
POLICY TERM:	January 1, 2025 through December 31, 2025
STATE OF ISSUE:	Colorado
POLICY ANNIVERSARY:	January 1, 2026

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

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

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

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

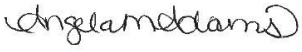
Premium due dates
Premium is due on the **premium due date** immediately following the date We invoice You.

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

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 IS A LIMITED BENEFIT HEALTH COVERAGE POLICY AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH THE COVERED PERSON'S TAXES.

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



Andrew M. DiGiorgio, President

Angela Adams, Secretary

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Policyholder Questions or Comments

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

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

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

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

Definitions

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

Covered activity

An activity or event that:

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

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 person

A person for whom all of the following applies:

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

Dates:

Effective date

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

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

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

Policy term
The period of time from 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 the **policyholder** and Us.

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

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

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

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

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

Premium Rate Changes

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

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

1. The terms of this **policy** change;
2. A change in any federal or state law or regulation is enacted, adopted or amended to the extent it affects **Our** benefit obligations under this **policy**;
3. The **policyholder** fails to provide sufficient information, as required by **Us**, to confirm adequacy of **premiums** and rates currently being paid.

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

Refund of Premium

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

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

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

Premium – Overdue Amounts

You shall pay Us interest on the total **premium** amount that is overdue. Overdue **premium** includes amounts due but not yet paid during the grace period. The interest rate will be up to 1-1/2% per month for each month or partial month an amount due remains unpaid.

We may also recover from You the costs of collecting any unpaid **premium**, including reasonable attorney fees and costs of suit.

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 of 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 grace period if You have not paid Us all **premiums** as of the end of the grace period.

Termination by You

You may end coverage under this **policy** if You give Us 31 days advance written notice. The 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:

- Immediately upon written notice to You if You perform any act or practice that constitutes fraud or if You make any intentional misrepresentation of a material fact relevant to the coverage.
- At any time after the end of the grace period if You have not paid the **premium**. We will give You written notice of the **termination date**.
- At any time if We give You 31 days advance written notice.

Effect of Termination

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

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

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

Notices – termination of coverage

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

Reinstatement
This **policy** may be reinstated if it lapsed for nonpayment of **premium**. Requirements for reinstatement are written application of the **policyholder** 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.

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

Certificates
Where required by law, the **company** will provide a certificate of insurance 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 of coverage and other materials
The **company**, or **policyholder,** 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.

General provisions

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

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

Entire Contract

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

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

These documents are the entire contract between Us and You.

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

Changes to the Policy

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

Legal Actions

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

Assignment and delegation

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

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

Clerical Error

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

Noncompliance with Policy Requirements

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

Discrimination prohibited

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

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

Financial Sanctions Exclusion

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

Incontestability

The validity of this **policy** will not be contested after it has been in force for 2 years from the **policy Effective Date**, except for non-payment of **premium**. **We** reserve the right to contest coverage at any time based upon the **Covered Person's** ineligibility for coverage under this **policy** or upon other provisions of this **policy**.

Records

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

Reporting Requirements

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

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

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

Non-Participating

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

Notices

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

Notice may be delivered:

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

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

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

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

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

Privacy

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

Policies and Procedures

We have the right to adopt reasonable policies, procedures, rules, and interpretations of this **policy** in order to promote orderly and efficient administration. You and all **Covered Person**s are bound by, and shall comply with, them. You will certify Your compliance with them upon Our request or as required specifically by this **policy**.

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:	ASSOCIATION RESOURCE GROUP
POLICY NUMBER:	MP0000859940
POLICY EFFECTIVE DATE:	January 1, 2025
POLICY TERM:	January 1, 2025 through December 31, 2025
STATE OF ISSUE:	Colorado
POLICY ANNIVERSARY:	January 1

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

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

The **certificate** and the coverage provided by it become effective at 12:00 A.M. at the address of the **policyholder** on the **policy** Effective Date shown above. It continues in effect in accordance with the provisions set forth in this **certificate**.

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

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

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

THIS CERTIFICATE CONTAINS A DEDUCTIBLE

PLEASE READ THIS CERTIFICATE CAREFULLY

NON-PARTICIPATING

THIS IS A LIMITED BENEFIT HEALTH COVERAGE POLICY AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

SIGNED FOR WELLFLEET INSURANCE COMPANY

Andrew M. DiGiorgio, President

Angela Adams, Secretary

Contact Us

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

Underwritten by Wellfleet Insurance Company

Administrator: Wellfleet Group, LLC
P.O. Box 15369
Springfield, MA 01115-3569
Toll free number: (877) 657-5039
www.wellfleetinsurance.com

Please have Your Certificate and Policy Number available when You contact us. It is on the front page of this Certificate.

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SCHEDULE OF BENEFITS

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

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

COVERED PERSONS:

Eligible Class(es) of Covered Persons	**Description of Class**
Class 1	All Club Members, Voluntary Helpers and Officials over the age of 18, including Stewards, Gatemen, Doctors, Veterinary Surgeons and the like, and all paid helpers over the age of 18, under the supervision or control of the **Policyholder**, excluding any employees paid by any person or entity under written contract to the **Policyholder**.
Class 2	All Club Members, Voluntary Helpers and Officials between the ages of 12 to 18, including Stewards, Gatemen, Doctors, Veterinary Surgeons, and the like, and all paid helpers between the ages of 12 to 18, under the supervision or control of the **Policyholder**, excluding any employees paid by any person or entity under written contract to the **Policyholder.**

COVERED ACTIVITIES:

Class 1 & Class 2	Participation in the following Policyholder supervised and sponsored activities: AKC Sponsored and Supervised events and Club sponsored and supervised events. Overnight supervised and sponsored activities with duration of more than 7 days and related travel are not covered unless specifically agreed to in writing by US. Covered travel included travel in the United States, its territories and possessions, Puerto Rico and Canada. This Coverage will not be in effect during travel to and Covered Activity that takes place outside of the United States, its territories and possessions, Puerto Rico and Canada, unless We have agreed to provide it in writing in advance.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS Class 1	
Principal Sum Amount Accidental Death Accidental Dismemberment	 $40,000 $40,000
Loss must occur within	365 days of the covered accident
Accidental Death and Dismemberment Aggregate Limit	$1,000,000
SCHEDULE OF COVERED LOSSES	
Covered Loss	**Benefit**
Loss of Life	**Principal Sum**
Loss of Both Hands or Both Feet	**Principal Sum**
Loss of One Hand and One Foot	**Principal Sum**
Loss of Sight of Both Eyes	**Principal Sum**
Loss of One Hand or foot and Sight of One Eye	50% of **Principal Sum**
Loss of One Hand or One Foot	50% of **Principal Sum**
Loss of Thumb and Index Finger of the Same Hand	25% of **Principal Sum**
Loss of all Four Fingers of the Same Hand	50% of **Principal Sum**
Loss of all the Toes of the Same Foot	50% of **Principal Sum**
Loss of Thumb	25% of **Principal Sum**
Loss of Sight in One Eye	50% of the **Principal Sum**
Loss of Speech and Hearing (in both ears)	**Principal Sum**
Loss of Hearing (in both ears)	**Principal Sum**
Loss of Speech	50% of the **Principal Sum**
Loss of Hearing in one ear	50% of the **Principal Sum**
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS Class 2	
Principal Sum Amount Accidental Death Accidental Dismemberment	 $5,000 $5,000
Loss must occur within	365 days of the covered accident
Accidental Death and Dismemberment Aggregate Limit	$1,000,000
SCHEDULE OF COVERED LOSSES	
Covered Loss	**Benefit**
Loss of Life	**Principal Sum**
Loss of Both Hands or Both Feet	**Principal Sum**
Loss of One Hand and One Foot	**Principal Sum**
Loss of Sight of Both Eyes	**Principal Sum**
Loss of One Hand or foot and Sight of One Eye	50% of **Principal Sum**
Loss of One Hand or One Foot	50% of **Principal Sum**
Loss of Thumb and Index Finger of the Same Hand	25% of **Principal Sum**
Loss of all Four Fingers of the Same Hand	50% of **Principal Sum**
Loss of all the Toes of the Same Foot	50% of **Principal Sum**
Loss of Thumb	25% of **Principal Sum**
Loss of Sight in One Eye	50% of the **Principal Sum**
Loss of Speech and Hearing (in both ears)	**Principal Sum**
Loss of Hearing (in both ears)	**Principal Sum**

Loss of Speech	50% of the **Principal Sum**
Loss of Hearing in one ear	50% of the **Principal Sum**

ADDITIONAL ACCIDENT INDEMNITY BENEFITS

Any benefits payable under the Additional Accident Indemnity Benefits shown below are in addition to any other Accidental Death and Dismemberment Benefits payable.

TOTAL DISABILITY WEEKLY INCOME BENEFIT	
Benefit Period	53 weeks
Total Disability must begin within	30 days of a **covered accident**
Weekly Disability Benefit	$200 for weeks 1-52, then $40,000 lump sum for week 53
Benefit Waiting Period	7 days

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 Class 1 & Class 2	
Full Excess Accident Medical Maximum	$10,000 per **covered accident**
Accident Medical **Coinsurance**	100% of **usual and customary charges**
Individual **disappearing** Medical **deductible**	$100 per **covered accident**
Benefit Period - Individual must be covered under this plan at the time of the **accident** causing the loss	52 weeks from the date of the **covered accident**
Treatment window: - First **covered expenses** must be **incurred** within	180 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 Visits	The **coinsurance** amount shown above after the Individual Medical **deductible** is met
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** combined
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
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 Devices	The **coinsurance** amount shown above after the Individual Medical **deductible** is met
Dental Services	up to a maximum of $2,000
Prescription Drugs	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

ELIGIBILITY

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

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

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

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

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**.

BENEFIT/COVERAGE (WHAT IS COVERED)

Scope of Coverage

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

We will pay benefits provided by this **certificate**, subject to all applicable conditions and exclusions, when the **covered person** suffers a loss or incurs **covered expenses** resulting directly and independently from a

covered accident that occurs while participating in a **policyholder sponsored, sanctioned and/or supervised covered activity**.

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

The **covered person** must be:

1. On the location or premises of the **policyholder**:
   a. During its normal hours;
   b. During scheduled functions; and
   c. During other periods while the **covered person** is participating in a **sponsored, sanctioned and/or supervised activity** of the **policyholder**.
2. Attending or participating in a one-day **sponsored, sanctioned and/or supervised activity** of the **policyholder**.
3. Traveling directly, without interruption:
   a. Between the **covered person's home** and the **policyholder** location or premises or the location of a **sponsored, sanctioned and/or supervised activity**; and
   b. 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 supervised by a coach, referee or by another adult specifically assigned supervisory duties and authority for that **covered activity** by the **policyholder**; and
5. Is within the scope of the activities provided by the **policyholder**.

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

DESCRIPTION OF BENEFITS

This Description of Benefits section describes the benefits provided by this **certificate**. **Any benefits are payable only once, even though more than one covered condition may apply. The covered injury must result directly and independently of all other causes from a covered accident.** Benefit amounts, **benefit periods** and any applicable aggregate and benefit-specific maximums are shown in the *Schedule of Benefits*.

Please read these and the *General Exclusion Sections* in order to understand all of the terms, conditions and limitations of coverage.

Accidental Death or Dismemberment Benefits

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

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

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

Definitions:

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

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

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

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

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

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

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

ADDITIONAL ACCIDENT INDEMNITY BENEFITS

Total Disability Weekly Income Benefit

We will pay weekly benefits to the **covered person** whose **total disability** results, directly and independently of all other causes from, and within the time period specified in the *Schedule of Benefits,* for a **covered accident** occurring while a **covered person** under this **certificate**. Disability benefits will begin when a **totally disabled covered person** satisfies the Benefit Waiting Period shown in the *Schedule of Benefits.*

Disability Benefits will begin on the date the **covered person** is **totally disabled**. The **covered person's total disability** must be certified by a **physician** and begin within the time period shown in the *Schedule of Benefits*.

Termination of Total Disability Benefits

Total d**isability** Benefits will end on the earliest of the date:

1. The **covered person** is no longer **totally disabled**;
2. Weekly disability benefits have been paid for the **benefit period** shown in the *Schedule of Benefits*;
3. The **covered person** fails to provide proof of continuing **total disability** when requested;
4. The **covered person** dies[;
5. The **covered person** is eligible to receive Accidental Death and Dismemberment benefits for the same **covered accident]**.

Benefits are based on a 7-day week. Any **disability** benefit payable for less than a full week will be pro-rated.

Once the **covered person** is eligible to receive **Total Disability** Weekly Income Benefits, separate periods of **total disability** will be considered one continuous period of disability if:

1. They result from the same **covered accident**; and
2. They are separated by no more than 14 consecutive days.

Definitions

For purposes of this Benefit:

Total Disability or Totally Disabled means either:

1. Inability of the **covered person** to do any type of work for which he or she is or may become qualified by reason of education, training or experience; or
2. Inability of the **covered person** to perform activities of daily living including eating, transferring, dressing, toileting, bathing, and continence, without human supervision or assistance.

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

ACCIDENT MEDICAL EXPENSE BENEFITS

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

The covered injury must result directly and independently of all other causes from a covered accident.

Covered expenses and any applicable **deductibles** are shown in the *Schedule of Benefits.*

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

Benefits will be paid:

1. When **covered expenses incurred** exceed any applicable **policy aggregate deductible** and individual medical **deductible** within the number of days from the date of the **covered accident** specified in the *Schedule of Benefits*;
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*; and
5. Until benefits paid under this **certificate** equal the **policy aggregate** maximum 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**:

1. After the **covered person** satisfies any applicable **deductible**; and
2. Without regard to any Coordination of Benefits provision in any **other health care plan**.

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

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

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

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

Accident Medical Expense Benefits

Covered Expenses

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

INPATIENT HOSPITAL SERVICES

Hospital Room and Board Expenses and miscellaneous services and supplies

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

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

Skilled nursing facility

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

Confinement in such Facility must:

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

OUTPATIENT FACILITIES

Ambulatory Medical or Surgical Center

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

Outpatient Hospital Surgical Services

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

Outpatient Hospital Non-Surgical Services

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

Emergency Room Expenses

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

Home Health Care

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

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

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

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

Rehabilitation Facility

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

PHYSICIAN SERVICES

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

Surgeon Expenses

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

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

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

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

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

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

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

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

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

OUTPATIENT X-RAYS, CT SCANS, MRI AND LABORATORY TESTS
Outpatient X-Rays, CT Scans, MRIs and Laboratory Tests

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

OUTPATIENT SERVICES AND SUPPLIES

Outpatient Physical Therapy

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

Outpatient Occupational and Speech Therapy

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

Nursing Services – Private Duty Nursing

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

Ambulance Services

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

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

Durable Medical Equipment and Orthopedic Braces and Appliances

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

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

Medical Services and Supplies

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

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

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

Prosthetic Devices

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

Dental Services

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

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

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

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

Definitions For purposes of this Benefit:

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

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

Exclusions

Benefits will not be payable if:

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

Prescription Drugs

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

1. Can only be obtained through a **physician**'s written prescription; and
2. Are approved for such prescription use by the Federal Drug Administration (FDA).

We will also pay **covered expenses incurred** for drugs for a **covered injury** that resulted 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**.

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. We** will pay the **covered expenses incurred** for the **Eyeglasses, Contact Lenses, Hearing Aids, Artificial Dental Devices** up to the maximum amount shown in the *schedule of benefits*.

LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED AND PRE-EXISTING CONDITIONS)

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. Expenses **incurred** after the end of the **Benefit Period**, even if **incurred** for continuing services or treatment of a **covered injury**.
3. Benefits provided by a Government plan (except Medicaid and other public assistance plans).
4. Injuries compensable under Workers' Compensation law or any similar law.
5. Declared or undeclared **war** or act of **war**.
6. Commission or attempt to commit a felony or an assault.
7. Commission of or active participation in a riot or insurrection.
8. Aggravation, during a **covered activity**, of an injury the **covered person** suffered before participating in that **covered activity**, unless **we** receive a written medical release from the **covered person's physician.**
9. Flight in, boarding or alighting from an aircraft, except as a fare-paying passenger on a regularly scheduled commercial or charter airline. This includes:
   a. A passenger in a military aircraft flown by the Air Mobility Command or its foreign equivalent.
10. Travel in or on any on-road and off-road motorized vehicle that does not require licensing as a motor vehicle.
11. An **accident** if the **covered person** is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless: (a) The **covered person** holds a valid learner's permit and (b) The **covered person** is receiving instruction from a Driver's Education Instructor.
12. **Sickness**, disease, bodily or mental infirmity, bacterial or viral infection or medical or **surgical** treatment thereof, except for any bacterial infection resulting from an **accidental** external cut or wound or **accidental** ingestion of contaminated food.
13. **Voluntary** ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a **physician** and taken in accordance with the prescribed dosage.
14. An **accident** that occurs while on active duty service in the military, naval or air force of any country or international organization. Upon **Our** receipt of proof of service, **we** will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days.
15. Treatment in any Veteran's Administration, Federal, or state facility, unless there is a legal obligation to pay.
16. Examination or prescriptions for, or purchase, repair or replacement of, eyeglasses, contact lenses except due to a **covered accident** as described elsewhere in this **certificate**.
17. Hearing aids, or purchase, repair or replacement of, except due to a **covered accident** as described elsewhere in this **certificate**.

18. Wheelchairs, braces, appliances, orthopedic braces, or orthotic devices except due to a covered accident as described elsewhere in this certificate.
19. A cardiovascular **accident** or stroke resulting, directly and in dependently of all other causes, from exertion, as verified by a **physician.**
20. Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the **covered person** has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the **covered accident** occurred.
21. Rest cures, long-term care or custodial care.
22. Cosmetic surgery or care, or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to:
    a. Cosmetic surgery resulting from a **covered accident**, if the **covered person's** initial treatment had begun within 12 months of the date of the **covered accident**;
    b. Reconstruction incidental to or following surgery resulting from a **covered accident**;.
    c. Any unplanned and unintended adverse consequences that may result during the treatment of a **covered accident**.
23. Any elective or routine treatment, surgery, health treatment, or examination, including any service, treatment or supplies that: (a) Are deemed to be experimental or investigational; and (b) Are not recognized and generally accepted medical practice in the United States.
24. Services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay.
25. Repair or replacement of existing dentures, partial dentures, braces or bridgework, unless damaged or destroyed in a **covered accident**.
26. Treatment or services provided by the **covered person's immediate family**.
27. Personal services, or comfort/convenience items such as television and telephone or transportation.
28. Orthopedic appliances used mainly to protect an injury.
29. Expenses payable by any automobile insurance **policy** without regard to fault.
30. Services or treatment provided by an infirmary operated by the **policyholder**.
31. Treatment of injuries that result over a period of time (such as blisters, tennis elbow, etc.), and that are a normal, foreseeable result of participation in the **covered activity**.
32. Treatment or service provided by a private duty **nurse** except due to a **covered accident** as described elsewhere in this **certificate**.
33. Charges for hot or cold packs for personal use.
34. Custodial Care service and supplies.
35. Expenses that are not recommended and approved by a **physician**.
36. Repair or replacement of existing artificial limbs, eyes and larynx, unless damaged or destroyed in a **covered accident**.
37. Treatment of hernia of any kind. Hernia means a rupture or protrusion of an organ or part through connective tissues or through a wall of a cavity in which it is normally enclosed.
38. Treatment of an injury resulting from or contributed to by frostbite, fainting or seizures, or heatstroke or heat exhaustion.
39. Participation in any sports activity not specifically authorized, sponsored and supervised by the **policyholder** , whether or not it takes place on **policyholder** premises .
40. Any expenses in excess of **usual and customary charges** except as provided in this **certificate**.
41. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.

42. Racing or speed contests, skin diving, or sky diving, mountaineering (where ropes or guides are customarily used), parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles), or other hazardous sport or hobby.
43. Non-physical, occupational, speech therapies (art, dance, etc.).
44. Modifications made to dwellings.
45. General fitness, exercise programs.
46. Use of electric, bio-mechanical devises.

MEMBER PAYMENT RESPONSIBILITY (CERTIFICATE PREMIUM PROVISION)

PREMIUMS
We provide insurance coverage in return for premium payment. The first premium is due on the Policy Effective Date. Each premium after that is due on the first day following the period for which the preceding premium was paid. The premium should be paid to us by the Insured Person or the Policyholder on or before the due date.

OUR RIGHT TO CHANGE PREMIUM RATES
We have the right to change Our premium rates. We will give the Policyholder at least 31 days prior written notice of any change.

GRACE PERIOD
After the first premium is paid, each subsequent premium due under this Certificate can be paid in the grace period. Any grace period will last 31; 45; 60 days after the premium due date. During this time, this Certificate will remain in full force. If a past due premium is not paid by the end of the grace period, this Certificate will lapse. The lapse date will be the last day of the grace period.

REFUND OF UNEARNED PREMIUM
If coverage under this Certificate for an Insured Person terminates for any reason, We will promptly refund any unearned premium with respect to such Insured Person.

CLAIM PROCEDURES (HOW TO FILE A CLAIM)

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

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

Claimant Cooperation Provision

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

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

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

Subject to written proof of loss, all accrued benefits for loss for which this **Certificate** provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of a written proof of loss, unless otherwise stated elsewhere in the certificate.

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

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

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

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

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

Written request shall be sent to:

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

The **covered person** or an authorized representative may also contact **us** by calling: 1-877-657-5039.

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

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

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

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

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

Legal Actions
No action at law or in equity will be brought to recover benefits under this **certificate** less than 60 days after 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 either of the following methods.

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

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

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**. 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**.

GENERAL POLICY PROVISIONS

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

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

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

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

Incontestability
The validity of the **policy** will not be contested after it has been in force for 2 years from the **policy** Effective Date, except for non-payment of premium, misrepresentation or fraud. **We** reserve the right to contest coverage at any time based upon the **covered person's** ineligibility for coverage under this **certificate** or upon other provisions of the **certificate**.

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

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

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

Certificate Changes

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

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

TERMINATION

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

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

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

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

INFORMATION ON POLICY AND RATE CHANGES

Your coverage can change
Your coverage is defined by the Policy. This document may have amendments or riders too. Under certain circumstances, We or or the law may change Your plan. Only We may waive a requirement of Your plan. No other person, including Your provider can do this.

We must give You 120 days advance written notice. Our amendment:

- Will not reduce benefits or coverage.
- Will not eliminate benefits or coverage.
- Will not increase benefits or coverage with a concurrent increase in premium during the current Policy term, other than increased benefits or coverage required by law.

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**.

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.**

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

1. Has an organized medical staff;

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

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

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

Coinsurance means the percentage of **usual and 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*.

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

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

Covered Activity means an activity or event that:
1. Takes place under one of the **conditions of coverage** specified in the **conditions of coverage** section of this **certificate***;* and
2. Is sponsored, organized, scheduled or otherwise provided by the **policyholder**.

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

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

Covered Injury means any bodily harm that results, directly and independently of all other causes, from a **covered accident** and occurs while such a person is participating in a **covered activity**. All **covered expenses** incurred as a result of the same or related cause (including any complications) shall be considered as resulting from one **covered injury**. A **covered injury** does not include aggravation of an injury sustained before the **covered accident**.

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

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

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

Deductible means the amount of **covered expenses** that the **covered person** must **incur**, as applicable, before benefits are paid under this **certificate**. The **deductible** 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.

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.

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

Home Health Care Agency means an agency that:

1. Is constituted, licensed and operated under the provision of Title XVIII of the Federal Social Security Act, or qualified to be so operated if application was made, and certified by the jurisdiction in which the **home health care plan** is established; and
2. Is engaged primarily in providing **skilled nursing facility** services and other therapeutic services in the **covered person's** home under the supervision of a **physician** or a **nurse**; and
3. Maintains clinical records on all patients.

Home Health Aide is a person who is not an **immediate family member** or anyone who lives with the **covered person** and:

1. Provides care of a medical or therapeutic nature, or who provides **daily living services**; and
2. Reports to and is under the direct supervision of a **home health care agency**.

Home Health Care means the continued care and treatment of the **covered person** if:

1. Institutionalization would have been required if **home health care** was not provided; and

2. The **covered person's physician** establishes and approves in writing the plan of treatment covering the **home health care** service.

Hospital means an institution that meets all of the following:

1. It is licensed as a **hospital** pursuant to applicable law;
2. It is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. It is managed under the supervision of a staff of medical doctors;
4. It provides 24-hour nursing services by or under the supervision of a graduate registered **nurse** (R.N.);
5. It has medical, diagnostic and treatment facilities, with major **surgical** facilities on its premises, or available on a prearranged basis;
6. It charges for its services.

The term **hospital** does not include a clinic, facility, or unit of a **hospital** for:

1. Rehabilitation, convalescent, custodial, educational or nursing care;
2. The aged, drug addicts or alcoholics;
3. A Veteran's Administration **hospital** or Federal Government **hospital**s unless the **covered person incurs** an expense and there is a legal obligation to pay.

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

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

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

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

Medically Necessary/Medical Necessity means care, services or supplies provided to the **covered person**, solely by or at the direction of a treating **physician** exercising prudent medical judgment and acting independently of **us**, for the purpose of evaluating, diagnosing or treating a **covered injury** sustained as the direct result of a **covered accident**, that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration;
3. Considered effective for the **covered injury**;
4. Not primarily for the convenience of the **covered person**, the **covered person's physician** or any other **physician**; and
5. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of a **covered injury**.

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

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

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

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

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

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

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

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

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

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

1. The **covered person**;
2. The **covered person's immediate family member or** the **covered person's** spouse;
3. A person living in the **covered person's** household;
4. A person employed or retained by the **policyholder**; or
5. A person providing homeopathic, aroma-therapeutic, or herbal therapeutic services.

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

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

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

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

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

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

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

Sickness means a physical or mental illness, including pregnancy.

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

Surgical Procedure means:

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

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

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

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

Special terms used

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

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

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

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

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

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice

- The views of **physicians** and dentists practicing in the relevant clinical areas

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

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

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

NOTICE OF PROTECTION PROVIDED BY LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION

This notice provides a brief summary of the Life and Health Insurance Protection Association ("the Association") and the protection it provides for policyholders. This safety net was created under Colorado law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Colorado law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- **Life Insurance**
  $300,000 in death benefits
  $100,000 in cash surrender or withdrawal values

- **Health Insurance**
  $500,000 in hospital, medical and surgical insurance benefits
  $300,000 in disability insurance benefits
  $300,000 in long-term care insurance benefits
  $100,000 in other types of health insurance benefits

- **Annuities**
  $250,000 in withdrawal and cash values

In general, the maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Colorado law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website www.colifega.org or contact:

Colorado Life and Health Insurance Protection Association 201 Robert S. Kerr Ave. Suite 600 Oklahoma City, OK 73102 1-800-337-7796	*Colorado Division of Insurance* 1560 Broadway, Suite 850 Denver, CO 80202 (303) 894-7499

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

HIPAA Notice of Privacy Practices

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

PLEASE REVIEW IT CAREFULLY

Effective: August 01, 2019

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

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

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

Our Responsibilities

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

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

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

Overview of this Notice

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

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

YOUR HEALTH INFORMATION

How We Acquire Your Information

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

How We use Your Health Information

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

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

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

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

Additionally:

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

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

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

Authorizations

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

YOUR RIGHTS

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

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

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

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

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

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

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

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

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

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

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

CONTACT

For all inquiries, requests and complaints, please contact:

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

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

This Notice is Subject to Change

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

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

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

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

COLLECTING YOUR INFORMATION

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

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

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

SHARING YOUR INFORMATION

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

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

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

HEALTH INFORMATION

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

SAFEGUARDING YOUR INFORMATION

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

ACCESSING YOUR INFORMATION

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

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

CORRECTING YOUR INFORMATION

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

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

CONTACTING US

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

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

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

NOTICE OF NON-DISCRIMINATION AND ACCESSIBIILITY REQUIREMENTS

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

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

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

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

1. Interpreters
2. information translated into other languages

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

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

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

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

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

ADVISORY NOTICE TO POLICYHOLDERS

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

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

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

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

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

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

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

LANGUAGE ASSISTANCE PROGRAM

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ىسراف (Farsi) هجوت :امشد نابز رگا دشاب یم امشد رایتخا رد نارگیار روط هب ینابز دادما تامدخ ،تسا.
(877) 657-5030 تمسا بیگرید.

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

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

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

សូមទូរស័ព្ទមកលេខ (877) 657-5030 ។

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

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

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

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

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

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

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

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

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