

## 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.

Coverage is non-contributory to the Covered Person.

### COVERED PERSONS:

Eligible Class(es) of Covered Persons	Description of Class
Class 1	all Sports participants coaches and managers of the policyholder stated on the application
Class 2	all eligible students of the policyholder when selected on the application

<b>ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS – Class 1 and Class 2</b>	
<b>Principal Sum</b>	\$10,000
<b>Loss must occur within</b>	365 days of the covered accident
<b>SCHEDULE OF COVERED LOSSES</b>	
<b>Covered Loss</b>	<b>Benefit</b>
Loss of Life	Principal Sum
Loss of Both Hands or Both Feet	Principal Sum
Loss of One Hand and One Foot	Principal Sum
Loss of Sight of Both Eyes	Principal Sum
Loss of One Hand or foot and Sight of One Eye	50% of Principal Sum
Loss of One Hand or One Foot	50% of Principal Sum
Loss of Thumb and Index Finger of the Same Hand	50% of Principal Sum
Loss of all Four Fingers of the Same Hand	50% of Principal Sum
Loss of all the Toes of the Same Foot	50% of Principal Sum
Loss of Thumb	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 Speech	50% of the Principal Sum
Loss of Hearing in both ears	50% of the Principal Sum

## ACCIDENT MEDICAL BENEFITS

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

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

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

### SCOPE OF COVERAGE APPLICABLE TO ACCIDENT MEDICAL BENEFITS – Class 1 Only

Full Excess Medical Maximum	\$1,000,000 per covered accident
Accident Medical Coinsurance	100% of usual and reasonable charges
Individual disappearing Medical deductible	\$0
<b>Benefit Period</b> - Individual must be covered under this plan at the time of the accident causing the loss	104 weeks from the date of the covered accident
Treatment window: - First covered expenses must be incurred within	90 days of the covered accident

### SCOPE OF COVERAGE APPLICABLE TO ACCIDENT MEDICAL BENEFITS – Class 2 Only

Full Excess Medical Maximum	\$10,000 per covered accident
Accident Medical Coinsurance	100% of usual and reasonable charges
Individual disappearing Medical deductible	\$0
<b>Benefit Period</b> - Individual must be covered under this plan at the time of the accident causing the loss	52 weeks from the date of the covered accident
Treatment window: - First covered expenses must be incurred within	90 days of the covered accident

### ACCIDENT MEDICAL BENEFITS – Class 1 and Class 2

Covered Expenses	Coverage and Other Limits
<b>Inpatient Hospital Services</b>	
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
<b>Skilled nursing facility</b>	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
<b>Outpatient Facilities</b>	
<b>Ambulatory Medical or Surgical Center</b>	The coinsurance amount shown above after the Individual medical deductible is met
<b>Outpatient Hospital Services</b>	The coinsurance amount shown above after the Individual medical deductible is met

Emergency Room Expenses	The <b>coinsurance amount</b> shown above after the Individual medical <b>deductible</b> is met
<b>Home Health Care</b>	The <b>coinsurance amount</b> shown above after the Individual medical <b>deductible</b> is met
Minimum <b>Inpatient hospital stay</b> , including <b>inpatient hospital stays</b> in a skilled nursing or rehabilitation facility, prior to receiving Home Health Care services	3 consecutive days
<b>Home health care</b> must begin within	10 consecutive days after the Minimum <b>Inpatient hospital stay</b>
Maximum Number of <b>home health care</b> visits	120 per <b>covered accident</b>
<b>Rehabilitation Facility</b>	The <b>coinsurance amount</b> shown above after the Individual medical <b>deductible</b> is met
Maximum Number of days	90 per <b>covered accident</b>
<b>Physician Services</b>	
Surgery	The <b>coinsurance amount</b> shown above after the Individual medical <b>deductible</b> is met
Assistant Surgeon	The <b>coinsurance amount</b> shown above after the Individual medical <b>deductible</b> is met
Urgent Care Expenses	The <b>coinsurance amount</b> shown above after the Individual medical <b>deductible</b> is met
Second Opinion or Consultation	The <b>coinsurance amount</b> shown above after the Individual medical <b>deductible</b> is met
Physician Assistant	The <b>coinsurance amount</b> shown above after the Individual medical <b>deductible</b> is met
Anesthesia and its Administration	The <b>coinsurance amount</b> shown above after the Individual medical <b>deductible</b> is met
In-Hospital or Office Visits	The <b>coinsurance amount</b> shown above after the Individual medical <b>deductible</b> is met
<b>Outpatient X-ray, CT Scan, MRI and Laboratory Tests</b>	
<b>Outpatient X-Rays, CT Scans &amp; MRIs and Laboratory Tests</b>	The <b>coinsurance amount</b> shown above after the Individual medical <b>deductible</b> is met
<b>Outpatient Services and Supplies</b>	
<b>Outpatient Physical Therapy</b>	The <b>coinsurance amount</b> shown above after the Individual medical <b>deductible</b> is met
Maximum Visits Per Day	1
Maximum <b>physical therapy</b> visits	20 per <b>covered accident</b>
<b>Outpatient Occupational and Speech Therapy</b>	The <b>coinsurance amount</b> shown above after the Individual medical <b>deductible</b> is met
Maximum Visits Per Day	1
Maximum <b>Occupational and Speech Therapy</b> visits combined	20 per <b>covered accident</b> combined
<b>Nursing Services- Private Duty Nursing</b>	The <b>coinsurance amount</b> shown above after the Individual medical <b>deductible</b> is met
<b>Ambulance Services</b>	The <b>coinsurance amount</b> shown above after the Individual medical <b>deductible</b> is met
<b>Durable Medical Equipment and Orthopedic Braces and Appliances</b>	The <b>coinsurance amount</b> shown above after the Individual medical <b>deductible</b> is met
Medical Services and Supplies	The <b>coinsurance amount</b> shown above after the Individual medical <b>deductible</b> is met

<b>Prosthetic Devices</b>	The <b>coinsurance amount</b> shown above after the Individual medical <b>deductible</b> is met
<b>Dental Services</b>	The <b>coinsurance amount</b> shown above after the Individual medical <b>deductible</b> is met
<b>Prescription Drugs</b>	The <b>coinsurance amount</b> shown above after the Individual medical <b>deductible</b> is met
<b>Eyeglasses, Contact Lenses, Hearing Aids, Artificial Dental Devices</b>	The <b>coinsurance amount</b> shown above after the Individual medical <b>deductible</b> is met
<b>Accidental Ingestion of Controlled Drugs</b>	The <b>coinsurance amount</b> shown above up to a maximum of \$500
<b>Other benefits – Class 1 Only</b>	
<b>Expanded Medical Benefit for Covered Sports Conditions</b>	Same as any other <b>covered loss</b> , subject to the limitations described in the benefit
Covered Sports Conditions	bursitis; sprains; hernia; muscle tears; tendonitis; stress fractures; shin splints; injury to joints and surrounding muscle and tissue; tennis elbow; and repetitive motion injuries
<b>Heart and Circulatory Conditions</b>	Same as any other <b>covered loss</b> , subject to the limitations described in the benefit
Covered Heart and Circulatory Conditions	heat exhaustion
First symptoms must be medically diagnosed within	24 hours of participation in a <b>covered activity</b>

## DEFINITIONS

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

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

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

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

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

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

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

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