WELLFLEET
SPECIAL RISK

2025–2026 Interscholastic Sports

Accident Plan

Notice to Parents

Your school board has purchased, at no cost to you, a Sports Accident Medical Insurance Plan to help cover medical expenses resulting from interscholastic sport injuries.

All players, coaches and managers of every interscholastic sport (including cheerleading) are covered throughout the entire school year. The program covers accidental bodily injuries occurring to a covered person while participating in or traveling, while under the supervision of proper school authority, to or from any regularly scheduled game or practice of an interscholastic sport.

The Plan your school has purchased may have a Deductible. Please check with your school or the Connecticut Representative listed in this brochure.

Benefits

The Schedule of Benefits provides a brief outline of the coverage and benefits provided by this plan. Please see the Certificate for full details.

Coverage is non-contributory to the Covered Person.

COVERED PERSONS: Eligible Class(es) of Covered Persons	Description of class
Class 1 (Sports)	all Sports participants coaches and managers of the policyholder stated on the application

Accidental Death and Dismemberment Benefits	
Principal Sum	$25,000
Loss must occur within	365 days of the covered accident
Schedule of Covered Losses	
Covered Loss	**Benefit**
Loss of Life	**Principal Sum**
Loss of Both Hands or Both Feet	**Principal Sum**
Loss of One Hand and One Foot	**Principal Sum**
Loss of Sight of Both Eyes	**Principal Sum**
Loss of One Hand or foot and Sight of One Eye	**50% of Principal Sum**
Loss of One Hand or One Foot	50% of **Principal Sum**
Loss of Thumb and Index Finger of the Same Hand	50% of **Principal Sum**
Loss of all Four Fingers of the Same Hand	50% of **Principal Sum**
Loss of all the Toes of the Same Foot	50% of **Principal Sum**
Loss of Thumb	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
Benefit Period - Individual must be covered under this plan at the time of the **accident** causing the loss	156 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	
Covered Expenses	**Coverage and Other Limits**
Inpatient Hospital Services	
Hospital Room & Board Expenses and miscellaneous services and supplies. Subject to Semi-Private room rate unless intensive care unit is required.	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Skilled nursing facility	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Minimum **Inpatient hospital stay** prior to confinement in **Skilled nursing facility.**	3 consecutive days per **covered accident**
Maximum Number of Skilled nursing facility days	120
Outpatient Facilities	
Ambulatory Medical or **Surgical Center**	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Outpatient Hospital Services	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Emergency Room Expenses	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Home Health Care	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Minimum **Inpatient hospital stay,** including **inpatient hospital stays** in a skilled nursing or **rehabilitation facility**, prior to receiving Home Health Care services	3 consecutive days
Home health care must begin within	10 consecutive days after the Minimum **Inpatient hospital stay**
Maximum Number of **home health care** visits	120 per **covered accident**
Rehabilitation Facility	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Maximum Number of days	90 per **covered accident**
Physician Services	
Surgery	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Assistant Surgeon	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Urgent Care Expenses	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Second Opinion or Consultation	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Physician Assistant	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Anesthesia and its Administration	The **coinsurance amount** shown above after the Individual medical **deductible** is met

In-Hospital or Office Visits	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Outpatient X-ray, CT Scan, MRI and Laboratory Tests	
Outpatient X-Rays, CT Scans & MRIs and Laboratory Tests	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Outpatient Services and Supplies	
Outpatient Physical Therapy	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Maximum Visits Per Day	1
Maximum **physical therapy** visits	20 per **covered accident**
Outpatient Occupational and Speech Therapy	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Maximum Visits Per Day	1
Maximum **Occupational and Speech Therapy** visits combined	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	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Prescription Drugs	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Eyeglasses, Contact Lenses, Hearing Aids, Artificial Dental Devices	The **coinsurance amount** shown above after the Individual medical **deductible** is met
Accidental Ingestion of Controlled Drugs	The **coinsurance amount** shown above up to a maximum of $500
Other benefits	
Deferred Dental Treatment Expense Benefits	The **coinsurance amount** shown above up to a maximum of $1,000
Expanded Medical Benefit for Covered Sports Conditions	Same as any other **covered loss**, 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
Heart and Circulatory Conditions	Same as any other **covered loss**, 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 **covered activity**

Important Notice . . . This is an Excess Plan

Full Excess Medical Expense

The Company will pay covered expenses, up to the Full Excess Medical Benefit shown in the Schedule of Benefits after the covered person satisfies any deductible, secondary to any other health care plan the covered person may have. Benefits payable will be limited to that part of the covered expense, if any, which is in excess of the total benefit payable for the same injury under any other health care plan:

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 the certificate will be matched with the other health care plan to allow 50% of any covered expenses up to the Full Excess Medical Benefit shown in the schedule of benefits. Benefits paid under the 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.

A covered person's entitlement to any other health care plan will be determined as if the 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 the 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.

Claims Procedures

Parents will be supplied with claim forms. When injuries are reported the claim form should be completed and sent within 30 days of loss, or as soon thereafter as reasonably possible to:
Wellfleet Insurance Company,
c/o Wellfleet Group, LLC, PO Box 15369, Springfield, MA 01115-5369.

accident only insurance, does not cover sickness

If you have any questions call: Colonna Insurance Services, LLC (203) 288-5936

Important: This brochure is a summary of benefits. Complete provisions pertaining to this plan are contained in the master policy on file at the school.

General Exclusions

In addition to any benefit-specific exclusion, benefits will not be paid for any covered injury, covered loss or covered expense which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the certificate::

1. Any service, treatment or supply that is not considered medically necessary as defined in the 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. "Active Participation" means voluntarily taking part. "Riot" means a civil disturbance with the intent of causing personal injury and/or property damage to nonparticipants.
8. Treatment of a pre-existing condition as defined herein.
9. 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.
10. Practice or play in any sports activity, including travel to and from the activity and practice except as specifically listed in the Schedule of Benefits.
11. Flight in, boarding or alighting from an aircraft, except as:
    a. A fare-paying passenger on a regularly scheduled commercial or charter airline;
    b. A passenger in a military aircraft flown by the Air Mobility Command or its foreign equivalent.
12. Travel in or on any on-road and off-road motorized vehicle that does not require licensing as a motor vehicle.
13. 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.
14. 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.
15. Travel or activity outside the contiguous United States, Alaska, Hawaii and the territories and possessions of the United States except as provided for qualified covered activity.
16. Voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed or taken under the direction of a physician and taken in accordance with the prescribed dosage.
17. 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.
18. Treatment in any Veteran's Administration, Federal, or state facility, unless there is a legal obligation to pay.
19. Examination or prescriptions for, or purchase, repair or replacement of, eyeglasses, contact lenses except due to a covered accident as described elsewhere in the certificate.
20. Hearing aids, or purchase, repair or replacement of, except due to a covered accident as described elsewhere in the certificate.
21. Wheelchairs, braces, appliances, orthopedic braces, or orthotic devices, except due to a covered accident as described elsewhere in the certificate.
22. A cardiovascular accident or stroke resulting, directly and in dependently of all other causes, from exertion, as verified by a physician.
23. Operating any type of vehicle while under the influence of alcohol. 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.
24. Rest cures, long-term care or custodial care.
25. 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.
26. 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.
27. Services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay.
28. Repair or replacement of existing dentures, partial dentures, braces or bridgework.
29. Treatment or services provided by the covered person's immediate family.
30. Personal services, or comfort/convenience items such as television and telephone or transportation.
31. Orthopedic appliances used mainly to protect an injury.
32. Expenses payable by any automobile insurance policy without regard to fault.

33. Services or treatment provided by an infirmary operated by the policyholder.
34. 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.
35. Treatment or service provided by a private duty nurse.
36. Charges for hot or cold packs.
37. Custodial Care service and supplies.
38. Expenses that are not recommended and approved by a physician.
39. Repair or replacement of existing artificial limbs, eyes and larynx, unless damaged or destroyed in a covered accident.
40. Treatment of an injury resulting from or contributed to by frostbite, fainting or seizures.
41. Participation in any sports activity not specifically authorized, sponsored and supervised by the school whether or not it takes place on policyholder premises.
42. Any expenses in excess of usual and reasonable charges except as provided in the certificate.
43. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning or, any professional sport.
44. 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.
45. Non-physical, occupational, speech therapies (art, dance, etc.).
46. Modifications made to dwellings.
47. General fitness, exercise programs.
48. Acupuncture charges.
49. Chiropractic care or spinal manipulation charges.

Benefit Specific Exclusions

In addition to any general 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 the certificate:

Heart and Circulatory Conditions

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

1. a heart or circulatory malfunction; or
2. hypertension, angina or other heart or circulatory condition.

This is a descriptive brochure, not a policy—plans subject to insurance department approval and as described in the Master Policy, Form Series No: CT PARTACC CCIC ADPOL(2018) et al, on file with the policyholder. Policy provides accident insurance only—does not cover sickness. Plan available only in Connecticut.

This document is meant to highlight some, but not all the features Wellfleet Coverage provides. It is not an insurance contract. Wellfleet Workplace Benefits provide limited benefits and is not a substitute for mandated ACA healthcare coverage. Like most supplemental offerings these benefits may have state-specific variations, and some product offerings and details may not be available in all states. Rates are subject to change. Wellfleet reserves the right to raise premium rates with proper notice as noted in the policy and proposal. For complete details contact your Wellfleet Sales Representative.

Wellfleet, Wellfleet Student, Wellfleet Special Risk, and Wellfleet Workplace are marketing names used to refer to the insurance and administrative operations of Wellfleet Insurance Company, Wellfleet New York Insurance Company, and Wellfleet Group, LLC (known in California only as Wellfleet Group, LLC dba Wellfleet Administrators, LLC). All insurance products are administered or managed by Wellfleet Group, LLC. Product availability is based upon business and/or regulatory approval and may differ among states.

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Wallingford, CT 06492
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Toll Free (888) 234-9910
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WELLFLEET SPECIAL RISK

Wellfleet Special Risk
Underwriting information:
Wellfleet Insurance Company
Fort Wayne, IN
As Policy Form Series:
GE PACC (2020) et al.

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