

## **A. THINGS YOU SHOULD KNOW**

### **When does my coverage begin and end?**

**You** are covered under this policy on the Effective Date shown on the Schedule of Benefits after:

- **You** have applied for coverage;
- **We** have approved **Your** application; and
- **You** have paid the required premium.

**Your** coverage ends on the Expiration Date shown on the Schedule of Benefits, subject to any prior cancellation by **you** or **us**.

### **Are there any significant and unusual exclusions or limitations?**

These are all set out full in the policy wording, but please note the following:

- The insurance excludes any known pre-existing medical conditions.
- There is an exclusion for losses arising from war or terrorism and from firearms and explosives.

### **Right to Examine and Cancel this Insurance Policy**

If **you** notify **us** that **you** are not completely satisfied with **your** purchased plan within 10 days of the date this **Policy** of Insurance was issued as indicated on **your** Certificate of Insurance, **we** will provide a full refund of premium as long as the **Covered Activity** has not started, nor have **you** filed a claim.

### **How do I file a claim?**

Online: <https://customers.vicoverage.com/>

## **B. SCHEDULE OF BENEFITS**

### **INDIVIDUAL ACCIDENT INSURANCE SCHEDULE OF BENEFITS**

INDIVIDUAL ACCIDENT INSURANCE SCHEDULE OF BENEFITS			
<b>Policyholder Name</b>	Policyholder name	<b>Policy Number</b>	Policy number
<b>Policyholder Mailing Address</b>	Mailing address	<b>Policyholder Email Address</b>	email
<b>Policy Period</b>	<b>Effective Date</b>		<b>Expiration Date</b>
	12:01 A.M. Standard Time at the Mailing Address of the Policyholder		
<b>Policy Premium</b>	Policy Premium		
The Policy Premium is based on the rates currently in force and on the limits of the insurance and benefits in effect.			
COVERED PERSON AND COVERED ACTIVITIES			
<b>Policyholder Covered Activity</b>	Spectator at Your Child's Covered Activity		
<b>Your Child's Name</b>	childs name		
<b>Your Child's Age at Policy Effective Date</b>	age		
<b>Your Child's Covered Activity</b>	sport		
<b>Organization Sponsoring Your Childs' Covered Activity</b>	organization		
Subject to all of the terms and conditions of the policy, benefits described in the policy are payable when <b>you</b> or <b>your child</b> suffers a <b>loss</b> as a result of an <b>accident</b> during a <b>covered activity</b> .			
BENEFITS AND LIMIT OF INSURANCE			
<b>Benefits</b>			<b>Limit of Insurance</b>
YOUR CHILD - ACCIDENT MEDICAL EXPENSE REIMBURSEMENT FULL EXCESS			\$5,000
Regardless of the number of <b>accidents</b> or covered <b>injuries</b> that occur during the <b>policy period</b> , <b>our</b> total limit of insurance for the <b>policy period</b> for all coverage and benefits provided under this policy shall not exceed the amounts shown above. For more details on the Limit of Insurance, please see section F. LIMITS OF INSURANCE			

## C. POLICY DEFINITIONS

Some words or phrases in the policy have been defined below. Defined words or phrases are printed in bold and have the following meanings, unless a different meaning is described in a particular coverage.

**Accident** - A sudden, unforeseeable event during the **policy period** causing **injury** to **you** or **your child**.

**Actual Cost(s)** - The standard costs and fees a **physician** would charge, regardless of whether that customer or patient has insurance coverage.

**Child** - **Your** dependent **child**, including a natural **child**, stepchild, or a **child** placed with **you** for adoption or foster care, who is under the age of 26 at the inception of the policy, shown on the Schedule of Benefits and for which a premium has been paid.

**Chiropractic Treatment** - **Treatment** by a licensed chiropractor operating within the scope of his or her license, consisting of the manipulation and/or adjustment of the spine, skeletal articulations, and adjacent tissue.

**Covered Activity** - The **activity(ies)** shown on the Schedule of Benefits that takes place during the **policy period** and within the **coverage territory**.

**Coverage Territory** - The United States, its territories and possessions.

**Injury(ies)** - Bodily harm caused by an **accident** that occurs during the **policy period**. All injuries sustained in one **accident**, including all related conditions and recurring symptoms of the injuries will be considered one injury.

**Loss** - An eligible benefit occurring during the **policy period**.

**Limit of Insurance** - The most **we** will pay under this policy for the coverage and benefits as shown on the Schedule of Benefits.

**Medical Expenses** - The following expenses **you** incur for the **treatment** that **you** or **your child** receives to treat a covered **injury**:

1. Medical services (including charges for anesthetics, x-ray examinations or treatments, and laboratory tests) and supplies, prescription drugs, and therapeutic services ordered or prescribed by a **physician**;
2. Hospital or ambulatory medical-surgical center services; and
3. Local ambulance services to and/or from a hospital.

**Medically Necessary** - **Medically Necessary** means:

- A **treatment**, service or supply that is required to treat an **injury**;
- Prescribed or ordered by a **physician** or furnished by a hospital;
- Performed in the least costly setting required by the condition;
- Consistent with the medical and surgical practices prevailing in the area for **treatment** of the condition at the time rendered.

The renting or purchasing of the following items are not considered **medically necessary**, including but not limited to: air conditioners; air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them; and general exercise equipment. The fact that a **Physician** may prescribe, authorize, or direct a service does not make it **medically necessary** or covered by this Policy.

**No Other Valid and Collectible Insurance Limit** - means the **limit of insurance** that applies when, at the time a covered loss occurs, the **you** do not have, and no benefits are available under, any other insurance policy, plan, program, or arrangement that would reimburse, indemnify, or otherwise provide payment for any portion of the covered loss as shown on the Schedule of Benefits.

**Other Valid and Collectible Insurance** - Any reimbursement for or recovery of any element of **Medical Expenses** incurred under this Policy and available from any other source whatsoever, except gifts and donations, but including without limitation:

1. Any individual, group, blanket, or franchise policy of Accident, disability or health insurance.
2. Any arrangement of benefits for members of a group, whether insured or uninsured.
3. Any prepaid service arrangement such as Blue Cross or Blue Shield; individual or group practice plans, or health maintenance organizations.
4. Any amount payable for hospital, medical or other health services for the accidental bodily **injury** arising out of a motor vehicle **accident** to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used including such benefits mandated by law) of any motor vehicle insurance policy.
5. Any amount payable for services or **injuries** or diseases related to **your** job to the extent that **you** actually received benefits under a Workers' Compensation Law. If **you** enter into a settlement to give up **your** rights to recover future **medical expenses** that would have
6. Social Security Disability Benefits, except that Other Medical Insurance shall not include any increase in Social Security Disability Benefits payable to **you** after **you** become disabled while insured hereunder.
7. Any benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.

**Physician** - A person who is a qualified practitioner of medicine. Such person must be acting within the scope of his/her license and under the laws in the state in which he or she practices and must be providing only those medical services which are within the scope of his/her license or certificate. Such person cannot be **you** nor a family member.

**Policy Period(s)** - The period specified on the Schedule of Benefits, subject to any cancellation prior to the scheduled expiration.

**Pre-existing Condition(s)** - An **injury**, illness, disease or other condition that in the 24-month period before this coverage became effective:

1. First manifested itself, worsened, became acute or exhibited symptoms that would have caused an ordinary or prudent person to seek diagnosis, care or **treatment**; or
2. Required taking prescribed drugs or medicines, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or
3. Was treated by a **physician** or **treatment** had been recommended by a **physician**.

**Treatment(s)** - Any **medically necessary** medical care administered and medications requiring a prescription that are prescribed by a **physician**, or under a **physician's** direct supervision, in treating **your** or your **child's injury**.

**You, Your** - The Named Insured as shown on the Certificate of Insurance- Schedule of Benefits.

**We, Us, Our** - Concert Speciality Insurance Company

## **D. BENEFIT PROVISIONS**

Upon **your** payment of the premium when due, and in reliance of the statements **you** made in the application, **we** will provide coverage as specifically described in this policy for **you** and for **your child** listed on the Schedule of Benefits. Unless stated to the contrary, all benefits are subject to all the terms, conditions, exclusions and limitations as stated herein and as shown on the Schedule of Benefits.

**ACCIDENT MEDICAL EXPENSES REIMBURSEMENT BENEFIT:** Subject to the full excess provision below, **We** will reimburse **you**, up to the **limit of insurance**, the **actual cost(s) of medical expenses** incurred by **you** for the **treatment you or your child** receives for an **injury** caused by an **accident** while participating in a **covered activity**. The **treatment** must be administered or prescribed within ninety (90) days of **your or your child's injury** to be eligible for reimbursement.

**CHIROPRACTIC CARE SUBLIMIT:** Notwithstanding the **Limit of Insurance** shown on the Schedule of Benefits, the maximum amount **we** will pay for **chiropractic treatment** is \$500 per **policy period**. This sublimit is part of, and not in addition to, the Accident Medical Expense Reimbursement Benefit limit shown on the Schedule of Benefits.

**FULL EXCESS PROVISION:** Insurance provided by this policy for this benefit shall be excess of all **other valid and collectible insurance**. If at the time of the **injury** there is **other valid and collectible insurance** or indemnity in place, then subject to the **Limit of Insurance** shown on the Schedule of Benefits, **we** shall be liable only for the difference between the excess of the amount of loss and the amount of such other insurance or indemnity. Recovery of **losses** from other parties does not result in a refund of premium paid.

## **E. WHAT WE DO NOT COVER**

1. This policy does not cover:

- i. Any **loss** if **you** have not complied with all conditions related to coverage set forth in this policy;
- ii. Any **pre-existing condition**;
- iii. **Treatment** rendered outside the **coverage territory**;
- iv. Experimental or elective **treatment**, routine physical examinations, hearing aids, eye glasses, contacts or hearing aids.

2. **We** will not reimburse **you** for any **injury** caused by, arising out of or related to, directly or indirectly, any of the following::

- i. An **accident** or **injury** that occurred before **you** and **your child** are covered by this policy;
- ii. An **accident** or **injury** that occurred outside the **coverage territory**;
- iii. Sickness, disease, or mental, nervous or psychological disorder or infirmity, including any medical or surgical **treatment** thereof;
- iv. Intentionally self-inflicted **injury**, suicide or attempted, while sane or insane;
- v. Participation in any kind of sporting or leisure activity for compensation or profit, including coaching or officiating;
- vi. Participation in a **covered activity** against medical advice;
- vii. **You** or **your child** traveling to or from the **covered activity**, including traveling to and from practice or special events related to the **covered activity**;

- viii. Being under the influence of alcohol or narcotics, unless administered on the advice of a **physician**, or performance-enhancing drugs;
- ix. **Injury** occurring after the **policy period**;
- x. **Injury** from any person's use of firearms or explosives;
- xi. War, invasion, acts of foreign enemies, hostilities between nations (whether declared or undeclared), or civil war; or an act of terrorism.

## F. LIMITS OF INSURANCE

1. **LIMITS OF INSURANCE:** Regardless of the number of **accidents** or covered **injuries** that occur during the **policy period**, **our** total **limit of insurance** for the **policy period** for all coverage and benefits provided under this policy shall not exceed the amount shown on the Schedule of Benefits.
2. **CONDITION PRECEDENT – EXISTENCE OF OTHER INSURANCE:** The **limit of insurance** applies only if **Other Valid and Collectible Insurance** exists at the time of **injury**. If no **Other Valid and Collectible Insurance** exists, the maximum amount payable under this policy shall be limited to the **No Other Valid and Collectible Insurance Limit** value shown on the Schedule of Benefits.

## G. CLAIM PROVISIONS

1. **NOTICE OF CLAIM:** Notice of a claim must be reported to **us** within thirty (30) days after the **accident** occurs. Late notices may be accepted if delays were unavoidable. Delays due to forgetfulness, busy schedules, or failure to read this policy are not unavoidable. **You** or someone on your behalf may give notice. The notice should provide sufficient information to identify **you**.
2. **CLAIM FORM:** When notice of claim is received by **us**, the forms for filing proof of loss will be furnished. If such forms are not furnished within fifteen (15) days after receipt of **your** notice, the proof of loss requirements can be met by **you** sending **us** a written statement of what happened. This statement must be received within the time given for filing proof of loss.
3. **PROOF OF LOSS :** Written proof of **loss** must be furnished to us within ninety (90) days after the date of such **loss**.

The following documentation must be submitted with the claim form:

- i. Receipts from the providers of service, stating the amount paid and listing the diagnosis and **treatment**;
- ii. Provide a copy of the final disposition of **your** claim under **your** primary medical or health insurance or other primary accident insurance.

Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of your legal capacity, later than one year from the time proof is otherwise required.

4. **PAYMENT OF LOSS:** Once **you** have provided written proof of loss, **we** will pay any benefits due to **you**, within thirty (30) days from the date of **our** receipt of all required information. This payment will include the effect of the deductible calculations and deducted non-coverable items, if applicable and any **limits of insurance**. **We** cannot preauthorize or guarantee coverage of a claim. Please keep in mind, **you** are financially responsible to the health service provider for payment of all **treatment**.
5. **EXAMINATION:** We have the right to have a **physician** of **our** choice at **our** own expense examine the person for who the claim is being made under this policy.
6. **COOPERATION:** Failure of a claimant to cooperate with us in the administration of a claim may result in the delay or termination of benefits. 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.

## H. GENERAL CONDITIONS

1. **RENEWABILITY:** This policy is short term, single premium and non-renewable at expiration. To obtain another policy, **you** must submit another application for a quote.
2. **CONCEALMENT, MISREPRESENTATION OR FRAUD:** **We** are not obligated to provide coverage under this policy if you at any time intentionally conceal, misrepresent or exaggerate a material fact concerning:
  - i. This policy;
  - ii. **You** or **your child**; or
  - iii. A claim under this policy.

The falsity of any statement **you** make shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by **us**.

3. **CONFORMITY TO STATE STATUTES:** Any policy provision which, on its effective date, is in conflict with the statutes of the state in which this policy was delivered or issued for delivery, is amended to conform to the minimum requirements of such statute.
4. **ENTIRE POLICY:** This policy, the Schedule of Benefits, the application and any endorsements contain all the agreements between **you** and **us**. The terms may not be changed or waived except by an endorsement issued by **us** and made a part of this policy.
5. **ELECTRONIC DELIVERY:** It is agreed that, unless otherwise notified by **you**, all written documents and communications regarding this policy, its endorsements, and any notices may be delivered to **you** by electronic mail using the email address associated with **your** policyholder account, except documents required to be delivered by another method. It is further agreed that it is your responsibility to keep **your** contact details, including email, telephone and postal address, current and correct.
6. **LEGAL ACTIONS:** No one may bring a legal action against **us** until there has been full compliance with all the terms of this policy. No action at law or in equity shall be brought to

recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. **You** will have three (3) years from the time written proof of loss is required to be furnished to take legal action against **us** with respect to recovery of a claim under this policy.

7. **OUR RIGHT TO RECOVER PAYMENT:** **We** reserve the right to recover from **you** any benefits **we** have paid for **injuries** received for a covered **accident** under: **you** at any time intentionally conceal, misrepresent or exaggerate a material fact concerning:

- i. Workers' Compensation or similar statutory remedies available under law; or
- ii. Any employer's liability insurance

8. **TIME LIMIT ON CERTAIN DEFENSES:** After 3 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by **you** in the application shall be used to void the policy or to deny a claim for loss incurred commencing after the expiration of such 3 year period. No claim for loss incurred commencing after 3 years from the date of issue of this policy shall be reduced or denied on the ground that a physical condition not excluded from coverage by name or specific description effective on the date of **loss** had existed prior to the effective date of coverage of this policy.