

BACK TO SCHOOL SCOUTING!



IT'S MORE THAN JUST CAMPING!

**FRIENDSHIP
CHARACTER BUILDING
LEADERSHIP TRAINING
COMMUNITY SERVICE
LIFE SKILLS
...AND MORE!**

When: Every Tuesday 630pm

**Where: Tolland Middle School Cafeteria
1 Falcon Way, Tolland, CT 06084**

Visit a troop meeting & find out what joining Troop 2 can do for you! We welcome boys from Tolland, Vernon, Willington and any surrounding towns.



SCAN ME



Questions: troop2tolland@gmail.com

WILLINGTON PARKS AND RECREATION



W I L L I N G T O N

BASKETBALL

REGISTRATION NOW OPEN!

REGISTRATION PACKETS ARE AVAILABLE ON
OUR WEBSITE, OR IN PERSON AT THE PARKS
AND RECREATION OFFICE

For more information, contact us at: (860) 487-3108 or jcallaghan@willingtonct.gov

PTA of Willington



Guilt Free Alternative Fundraiser / Membership Drive

- \$12.00 - I would love to be a member and have a hand at bettering my student's education and school experience
- \$15.00 - I want to be a member but I don't want to bake cupcakes, so here's the money I would have spent on cupcakes.
- \$25.00 - I want to be a member, but I don't want to hit up friends and family for money, so here's the money I would have spent on cookie dough.
- \$50.00 - I want to be a member but I don't want to walk, run, or swim, in any "-thon", so here's the money I would have spent on my "free" shirt.
- \$75.00 - I want to be a member but I don't want to hit up any local businesses to sponsor a gift basket for a silent auction, so here's the money I would have spent on gas, cellophane, gift cards, and ribbon.
- \$100.00 - I want to be a member but I really wouldn't have helped anyway, so here's \$100 to forget my name.
- \$_____ - Here's my donation to express my gratitude for not having to buy make, sell, or do anything other than fill out this paper.

Name: _____ **Phone:** _____

Student : _____ **Grade/Teacher:** _____

Student : _____ **Grade/Teacher:** _____

Student : _____ **Grade/Teacher:** _____

Email: _____

Cash/Check/Amount Enclosed: _____

Payments can be: Dropped of/sent to the school attention: "PTA of Willington", Checks made out to "PTA of Willington", **OR**, mailed to "PTA of Willington" at P.O.

Box 42, Willington, CT 06279, **OR**, sent via PayPal using the following email:

membership.willingtonpta@gmail.com



2021–2022 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	\$10,000
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

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	104 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	
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

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 of 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.

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.*

This document is meant to highlight some, but not all the features Wellfleet Coverage provides. It is not an insurance contract.

Wellfleet Special Risk provides 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 is the marketing name used to refer to the Insurance and administrative operations of Wellfleet Insurance Company, Wellfleet New York Insurance Company, and Wellfleet Group, 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 companies.

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UNDERWRITTEN BY:



Wellfleet Insurance Company
Fort Wayne, IN

As Policy Form Series:
CT PARTACC CCIC ADPOL(2018) et al.

ADMINISTERED BY:



Wellfleet Group, LLC
P.O. Box 15369
Springfield, MA 01115-5369

CONNECTICUT REPRESENTATIVE:



P.O. Box 4245 • Hamden, Connecticut 06514
Telephone: (203) 288-5936 • Fax: (203) 230-2211
Toll Free (888) 234-9910
www.colonnainsurance.com

Help Wanted in Willington

Willington Board of Education Recording Secretary

\$100/meeting

Meetings are held on the second Tuesday of each month at 7:00 p.m. and posted on YouTube. The Recording Secretary is responsible for reviewing the recording and independently typing the minutes into a standard format.

If interested, please email Superintendent Phil Stevens at pstevens@willingtonct.org or call 860-487-3130 for more information.

E.O.E.

Willington Public Schools 2023 - 2024 Calendar

August/September 2023 (21)

M	T	W	Th	F
SD	SD	30	31	1
H	5	6	7	8
11	12	13	14	15
18	19	20	21	22
25	26	27	28	29

August
 28-29 Staff development....Schools closed for students
 30 Meet & Greet.....Schools closed for students
 31 First day for students

September

4 Labor day.....Schools closed
 15 Student early dismissal, 1/2 Staff development

October

6 Student early dismissal, 1/2 Staff development
 9 Columbus Day.....Schools closed
 10 Staff developmentSchools closed for students

November

20-21 Parent Conferences, student early dismissal
 22 Early dismissal
 23-24 Thanksgiving recess.....Schools closed

December

1 Student early dismissal, 1/2 Staff development
 22-29 Winter recess.....Schools closed

January

1 New Years' Day.....Schools closed
 15 Martin Luther King Day.....Schools closed

February

15 Student early dismissal, 1/2 Staff development
 16 Staff development....Schools closed for students
 19 Presidents' Day.....Schools closed
 20 Vacation Day.....Schools closed

March

15 Student early dismissal
 29 Good Friday.....Schools closed

April

15-19 Spring Recess.....Schools closed

May

24 Student early dismissal, 1/2 Staff development
 27 Memorial Day.....Schools closed

June

11 Last day of school, early dismissal for students
 12 Teacher work day

Childcare provided on the following
early release days...

9/15/23, 10/6/23, 12/1/23, 2/15/24, 3/15/24, 5/24/24

June 12-28 Days reserved as makeup days if needed due to weather related closings
Approved 2.14.2023

Phil Stevens, Superintendent
860.487.3130

February 2024 (19)

M	T	W	Th	F
			1	2
5	6	7	8	9
12	13	14	15	SD
H	V	21	22	23
26	27	28	29	

March 2024 (20)

M	T	W	Th	F
				1
4	5	6	7	8
11	12	13	14	15
18	19	20	21	22
25	26	27	28	H

April 2024 (17)

M	T	W	Th	F
1	2	3	4	5
8	9	10	11	12
V	V	V	V	V
22	23	24	25	26
29	30			

May 2024 (22)

M	T	W	Th	F
		1	2	3
6	7	8	9	10
13	14	15	16	17
20	21	22	23	24
H	28	29	30	31

June 2024 (7)

M	T	W	Th	F
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21
24	25	26	27	28

October 2023 (20)

M	T	W	Th	F
2	3	4	5	6
H	SD	11	12	13
16	17	18	19	20
23	24	25	26	27
30	31			

November 2023 (20)

M	T	W	Th	F
		1	2	3
6	7	8	9	10
13	14	15	16	17
20	21	22	H	H
27	28	29	30	

December 2023 (15)

M	T	W	Th	F
				1
4	5	6	7	8
11	12	13	14	15
18	19	20	21	V
V	V	V	V	V

January 2024 (21)

M	T	W	Th	F
H	2	3	4	5
8	9	10	11	12
H	16	17	18	19
22	23	24	25	26
29	30	31		