NATIONWIDE LIFE INSURANCE COMPANY

(Herein called the Company)

Home Office: P.O. Box 2399, Columbus, Ohio 43216

CERTIFICATE OF INSURANCE

MEMBER: Donelson Baseball Babe Ruth League

ADDRESS: PO Box 531
Hermitage, TN, 37076

The Company hereby certifies that the Member shown above is insured under Policy Number 6A SPP-266489-00 which it has issued to:

BABE RUTH LEAGUE, INC.
1770 BRUNSWICK PIKE
TRENTON, NJ 08638

The Company will provide the insurance described herein. All of the benefits and provisions of this program of insurance will be determined in accordance with all of the terms of the Policy.

COVERAGE PERIOD: From 12:01 AM on 02/01/2015 to Midnight on 1/31/16

All insurance under this Certificate will terminate on the earlier of the date of termination of the Policy, or at midnight on the last day of the Coverage Period shown above, without prejudice to any claim incurred while this Certificate is in force.

Insured Person means rostered players, managing personnel (bat and ball boys/girls, score keepers, umpires and league officials), volunteers, persons trying out for team positions or persons acting in the capacity of managing personnel during preseason tryout sessions and Ladies Auxiliary/Booster Club members; includes these persons and registered campers at the Babe Ruth League, Inc. sponsored baseball camp and World Series participants.

Covered Event means a Babe Ruth League, Inc. approved baseball/ softball activity, practice sessions and baseball/softball games scheduled and supervised by Babe Ruth League, Inc. or one of its member leagues. Covered Event includes any period when the Insured Person is participating under the direct supervision of the proper authorities of the league in approved tournament games as a member of the tournament team and while staying at the place of the tournament game. Covered Event includes Covered Travel as defined below.

Covered Travel means team or group travel to or from the site of a Covered Event under the supervision of a coach or designated representative of Babe Ruth League, Inc. or one of its member leagues.

This certificate is subject to the laws of the state of New Jersey.

BLANKET ACCIDENT BENEFITS CERTIFICATE

TABLE OF CONTENTS

SECTION 1

GENERAL DEFINITIONS

1. “Accident” or “Accidental” means an unforeseen, unexpected and unintended occurrence.

2. “Injury” or “Bodily Injury” means bodily injury which results directly from an Accident and which is independent from disease, sickness or other bodily infirmity.

3. “Covered Accident” means an Accident which occurs while the Policy is in force at a Covered Event.

4. “Covered Event” means those events and activities specified on the face page.

5. “Doctor” means a licensed physician, chiropractor, physical therapist, or other practitioner of the healing arts acting within the scope of his or her license.

6. “Insured Person” means those persons specified on the face page.

7. “Intoxication” or “Intoxicated” means that the level of alcohol in the Insured Person’s blood is found to be at the time of injury at or above the level a person is presumed to be intoxicated in the jurisdiction where the Covered Accident occurred.

SCHEDULE OF INSURANCE
(hereinafter referred to as Schedule)

Initial Premium	PER INVOICE

SUBSEQUENT PREMIUMS

PREMIUM DUE DATE	AMOUNT DUE
PER INVOICE	PER INVOICE

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Principal Sum	$10,000.00

ACCIDENT MEDICAL EXPENSE BENEFITS

Covered Accident Deductible Amount	$100.00 or, if greater, the amount of benefits applied for on behalf of the Insured Person; Covered Expenses from all Disablements will be combined for the purpose of satisfying the Deductible Amount.
Coinsurance Percentage	100 %
Deductible Establishment Period	6 Months
Benefit Period	12 Months
Qualifying Period	365 Days
Maximum Benefit Limit for other than Covered Travel	$250,000.00
Maximum Benefit Limit for Covered Travel	$100,000.00
Daily Room and Board Limit	
For Private or Semi-Private Room	The Average Semi-Private Rate of the Hospital in Which Confined
For Intensive or Special Care	Reasonable and Customary Charge

LIMIT OF AGGREGATE LIABILITY	**NONE**

SECTION 3

CERTIFICATEHOLDER PROVISIONS

PREMIUM

The initial premium must be paid on or before the effective date unless otherwise agreed to in writing by the Company. Subsequent premiums, if any, must be paid on or before the due dates or insurance will cease in accordance with the Grace Period provision described below.

TERM OF POLICY AND CERTIFICATES

The Policy is issued for the term specified in its face page. The Policyholder may terminate the Policy at any time by giving written notice to the Company. Such termination will be effective on the latter of

a. the date the notice is received by the Company, and

b. the day specified in the notice.

The Company will make a refund of any premium paid for periods after the termination date.

This Certificate is issued for the Coverage Period shown on its face page. The Certificateholder may terminate it at any time by giving written notice to the Company. Such termination will be effective on the latter of

a. the date the notice is received by the Company, and

b. the day specified in the notice.

The Company will make a refund of any premium paid for periods after the termination date.

GRACE PERIOD

If the Policyholder has not previously given written notice to the Company that the Policy is to be terminated, a grace period of thirty-one (31) days, without interest charge, will be granted to the Policyholder for payment of every premium except the initial premium. During the grace period, the Policy will continue in force.

REINSTATEMENT

The Policy may be reinstated with the written consent of the Company. Application for reinstatement must be made by the Policyholder on forms provided by the Company. The Company will act promptly on an application for reinstatement. Failure of the Company to respond to any application for reinstatement within thirty (30) days of its receipt will automatically reinstate the Policy. All correspondence between the Company and the Policyholder concerning reinstatement must be conducted in writing.

RENEWAL

The Policy may be renewed with the mutual consent of the Policyholder and the Company. At least thirty (30) days before the Policy's ending date shown on the face page, the Company will advise the Policyholder in writing of the cost of continuing the Policy for another term unless it has advised the Policyholder of its intention to discontinue the policy.

SECTION 4

BENEFIT PROVISIONS
ACCIDENTAL DEATH AND DISMEMBERMENT

The Company will pay the amount shown in the Table of Losses for a listed loss which:

a. results solely from an Injury to the Insured Person which occurs during a Covered Event, and from no other contributory cause; and

b. is sustained within one year after the date of the Injury.

TABLE OF LOSSES

FOR LOSS OF:	AMOUNT PAYABLE:
Life	The Principal Sum
Both Hands	The Principal Sum
Both Feet	The Principal Sum
Sight of Both Eyes	The Principal Sum
One Hand and One Foot	The Principal Sum
One Hand and Sight of One Eye	The Principal Sum
One Foot and Sight of One Eye	The Principal Sum
Speech or Hearing (both ears)	One-Half the Principal Sum
One Hand	One-Half the Principal Sum
One Foot	One-Half the Principal Sum
Sight of One Eye	One-Half the Principal Sum
Hearing of One Ear	One-Half the Principal Sum
Finger or toe, each	$500 or 2% of the Principal Sum, whichever is less
Permanent, natural and sound teeth	Single: $25; Each additional: $10

Loss of hands and feet means loss by severance at or above the wrist or ankle joint or total and irrecoverable loss of use of these members as a result of damage to tissue of that member.

Loss of finger or toe means total and irrecoverable loss of entire phalanges.

Loss of sight, speech or hearing means their total and irrecoverable loss.

In the event of multiple losses resulting from a single covered accident, only the largest amount payable will be paid.

SECTION 4

BENEFIT PROVISIONS
ACCIDENTAL DEATH AND DISMEMBERMENT
(continued)

EXCLUSIONS AND LIMITATIONS

No benefits are payable under this benefit provision for any loss caused or contributed to by:

a. illness, or medical or surgical treatment thereof, including diagnosis;

b. bacterial infection, except septic infection of and through a wound accidentally sustained;

c. intentionally self-inflicted injury;

d. a state of war or any act of war whether or not the Insured Person is in the armed services;

e. participation in a riot or insurrection or as the result of the commission of a felony by the Insured Person;

f. travel or flight in or descent from any aircraft, unless the Insured Person is a fare-paying passenger on a regularly scheduled flight on a commercial airline; or is a passenger on an aircraft chartered solely for the purpose of travel which has a valid airworthiness certificate from the jurisdiction in which operated and which is being operated by a duly licensed pilot;

g. nuclear risk or incident.

BENEFICIARY

The beneficiary of the Insured Person is the person designated by him or her, on a form satisfactory to the Company, to receive any amount of insurance becoming payable under the terms of the Policy on account of his or her death.

An Insured Person may change the beneficiary without the consent of any designated beneficiary, prior to designation of an irrevocable beneficiary, by filing written notice of the change on a form satisfactory to the Company. The new designation will be effective when the notice is received by the Company. The Company will not be liable for any payments it makes before receiving the notice. A new designation of beneficiary terminates the interest of any previous beneficiary.

If more than one beneficiary is designated, but their respective interests are not specified, they will share equally. The interest of a beneficiary predeceasing the Insured Person will terminate and be shared equally by beneficiaries surviving the Insured Person, unless otherwise provided in the beneficiary designation.

SECTION 4
BENEFIT PROVISIONS
ACCIDENT MEDICAL BENEFITS

The Company will pay the coinsurance percentage of "Covered Expenses" in excess of the Covered Accident Deductible Amount incurred by an Insured Person:

a. in each Benefit Period:
b. as a result of a Disablement.

The amount payable will not exceed the Maximum Benefit Limit shown on the Schedule (Section 2).

"Disablement" means an Injury sustained in a Covered Accident. All Injuries sustained in any one accident are considered one Disablement.

COVERED EXPENSES

For the purpose of these benefits, the term "Covered Expenses" means the reasonable and customary expenses incurred by or on behalf of an Insured Person for those services and supplies listed below which are: administered or ordered by a Doctor; medically necessary to the diagnosis and treatment of any injury; and not excluded by any provision of the Policy.

Covered Expenses are limited to charges:

1. made by a Hospital for:
   i. daily room and board and general nursing services, or confinement in an intensive care unit, not to exceed the applicable maximum limits shown in the Schedule;
   ii. use of an operating, treatment or recovery room; and
   iii. emergency treatment even if confinement is not required.
2. made by a Doctor for professional services;
3. made by a licensed nurse, occupational therapist or physical therapist (who is not a member of the Insured Person's immediate family);
4. for professional ambulance service to and from a Hospital for necessary emergency care;
5. for drugs requiring the written prescription of a Doctor;
6. for diagnostic tests;
7. for the processing and administration of blood and blood components;
8. for oxygen and other gases and their administration;
9. for the cost and administration of an anesthetic;
10. for dressings, sutures, casts, splints, trusses, crutches, braces (except dental braces or corrective shoes), or other necessary medical supplies;
11. for the rental of a wheelchair, hospital bed or other durable medical equipment required for temporary therapeutic use, or the purchase of this equipment if economically justified, whichever is less;
12. for confinement in an Extended Care Facility which commences within five (5) days of a Hospital confinement of five (5) days or more;
13. for Home Health Care which is

a. established and approved in writing by a Doctor and

b. commences within seven (7) days of a Hospital confinement of five (5) days or more;

14. for artificial limbs, eyes or larynx (but not their replacement).

SECTION 4

BENEFIT PROVISIONS
ACCIDENTAL MEDICAL BENEFITS
(continued)

DEFINITIONS

1. "Extended Care Facility" means an institution operating pursuant to the law or regulations where it is located

a. which has facilities for ten (10) or more inpatients;

b. which is engaged in providing skilled nursing care and related services under the supervision of a Doctor and Registered Nurses to persons recovering from illness or injury; and

c. which maintains written records of the medical treatment of each of its patients.

2. "Home Health Care" means nursing care and treatment in a person's home by a Hospital certified to provide Home Health Care Services or by a certified Home Health Care agency. It includes daily living care services, such as, cooking, feeding, bathing, dressing, and personal hygiene, which the Insured Person is unable to perform for himself or herself.

3. "Hospital" means an institution which meets all of the following requirements;

a. it is licensed (if required) as a Hospital;

b. it is open at all times;

c. it is operated mainly to diagnose and treat illnesses and injuries on an inpatient basis;

d. it has a staff of one (1) or more Doctors on call at all times;

e. it provides nursing services by Registered Nurses twenty-four (24) hours a day;

f. it is not, other than incidentally, a skilled nursing facility, clinic, nursing home, rest home, convalescence home or similar institution; and

g. it has organized facilities for major surgery or provides for such facilities for its patients through formal written agreement with other Hospitals.

4. As to professional fees, the term "reasonable and customary" means that the charge is not in excess of the most common charge for similar professional services in the locality where the services are received. If the charge is in excess of the most common charge, no payment will be made with respect to the excess, and the excess will not qualify as a Covered Expense under the Policy. The "most common charge" for any given service and locality will be determined in good faith by the Company.

As to other services or supplies, "reasonable and customary" charges will be determined in good faith by the Company, using a comparison of charges made by other providers of similar services or supplies in the locality where the services or supplies are received. No payment will be made with respect to any amount in excess of the "reasonable and customary" charge.

5. "Pre-Existing Condition" means a condition for which the Insured Person received medical advice or treatment by a Doctor within twenty-four (24) months prior to his or her becoming insured under the Policy.

SECTION 4

BENEFIT PROVISIONS
ACCIDENTAL MEDICAL BENEFITS
(continued)

EXCLUSIONS AND LIMITATIONS

Covered Expenses will never include, and no benefits will ever be payable for any charges which:

a. exceed the reasonable and customary charges;

b. are incurred for dental work unless the Insured Person sustains a Disablement which results in damage to his or her natural teeth;

c. are incurred for television, telephone, water pitcher, and other personal convenience items, or expenses for other persons, except as may be specifically provided for elsewhere;

d. are incurred for services or supplies not specifically provided for in the Policy;

e. which would not have been made in the absence of insurance or which the Insured Person is not legally obligated to pay;

f. result from an intentionally self-inflicted injury;

g. arise out of the Insured Person's participation in a riot or his or her commission of a felony;

h. are incurred for cosmetic procedures, unless made necessary by a Disablement;

i. are incurred for eyeglasses, contact lenses or hearing aids or for any examination or fitting related to these devices unless made necessary by a Disablement;

j. are incurred for care or treatment which is not medically necessary to the diagnosis or treatment of a Disablement;

k. are incurred for the professional services of a person who is a member of the Insured Person's immediate family;

l. are incurred for care which is custodial in nature;

m. are incurred for experimental treatment or procedures;

n. are incurred for articles of clothing which are intended for use more than once;

o. are incurred for treatment of a Pre-Existing Condition, unless

1. During the period immediately preceding coverage under the Policy, the Insured Person was covered under another blanket accident benefits Policy issued by the Company, and

2. The Company paid benefits for the condition under the blanket accident policy under which the Insured Person was previously insured;

p. arise out or war, invasion, acts of foreign enemies, civil war, rebellion, insurrection or insurgencies; and

q. arise out of nuclear risk or incident.

SECTION 4

BENEFIT PROVISIONS
ACCIDENTAL MEDICAL BENEFITS

COVERED ACCIDENT DEDUCTIBLE AMOUNT

The "Covered Accident Deductible Amount" to be deducted from the total Covered Expenses incurred by each Insured Person for each Benefit Period, will be the Deductible Amount shown in the application of the Policyholder.

Only those Covered Expenses incurred during the Qualifying Period shown in the Schedule will be used to satisfy the Covered Accident Deductible Amount.

The Covered Accident Deductible Amount will not apply to Covered Expenses specifically identified in the Schedule as not being subject to it.

If no Covered Expenses are incurred within the Deductible Establishment Period following the Covered Accident, no Benefit Period will begin and no benefits will be payable for that Disablement.

QUALIFYING PERIOD

The "Qualifying Period" shown in the Schedule is the period of time within which the Covered Accident Deductible Amount must be satisfied. It begins on the date of the Covered Accident.

MAXIMUM BENEFIT LIMIT

The "Maximum Benefit Limit" shown in the Schedule, is the total benefit payable for eligible Covered Expenses incurred during a Benefit Period.

EXTENDED COVERAGE

Termination of an Insured Person's insurance under the Policy shall not affect benefits payable for any Disablement originating prior thereto.

BENEFIT PERIODS

"Benefit Period" means that period which:

- **a.** begins on the date of the Covered Accident; and
- **b.** ends
    - i. on the expiration of the Benefit Period shown in the Schedule, or
    - ii. if earlier, at the end of any period of twelve (12) months during which less than $500 of Covered Expenses are incurred by the Insured Person.

"Benefit Period" will be not less than 36 months with respect to the removal of internal fixation devices installed in an Insured Person as the result of a Covered Accident.

SECTION 5

GENERAL EXCLUSIONS AND LIMITATIONS

This Policy does not cover, and no payment will be made for any loss or expense arising out of Injury caused by or resulting from:

- **a.** self-destruction or attempts of self-destruction while sane, or intentionally self-inflicted injury;
- **b.** the attempt by the Insured Person to commit a felony;
- **c.** the Insured Person's being intoxicated;
- **d.** the use by the Insured Person of narcotics unless administered on the advice of a Doctor;
- **e.** illness or disease, except:
  - **1.** as may result from an Injury sustained in a Covered Accident;
  - **2.** a cardiovascular accident, stroke or other similar traumatic event caused by exertion while participating in a Covered Event;
  - **3.** the aggravation of a condition such as tendonitis, strains, sprains and other similar conditions caused by exertion while participating in a Covered Event;
- **f.** war, invasion, acts of foreign enemies, civil war, rebellion, insurrection or insurgencies;
- **g.** nuclear risk or incident.

The liability of the Company will not exceed the Limit of Aggregate Liability shown on the Schedule for all losses or expense resulting from a single Covered Accident or a single conveyance. If this amount is insufficient to pay all claims, each claim or loss will be paid at the ratio of the Limit of Aggregate Liability to the actual total liability resulting from the Covered Accident.

SECTION 6
UNIFORM PROVISIONS

NOTICE OF CLAIM

Written notice of any Injury which may lead to a claim under the policy must be given to the Company within 30 days after the Injury, or as soon thereafter as is reasonably possible. Failure to give notice within such time shall not invalidate nor reduce any claim if it is shown that notice was given as soon as was reasonably possible.

CLAIM FORMS

The Company, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If these forms are not furnished within 15 days after the notice is sent, the claimant may comply with the proof of loss requirements of the policy by submitting within the time fixed in the Policy for filing proofs of loss, written proof showing the occurrence, nature and extent of the loss for which claim is made.

PROOFS OF LOSS

Written proof of loss must be furnished to the Company within ninety (90) days after the date of loss. However, in case of claim for loss for which the Policy provides any periodic payment contingent upon continuing loss, this proof must be furnished within ninety (90) days after termination of each period for which the Company is liable. Failure to furnish proof within the time required will not invalidate nor reduce any claim if it is not reasonably possible.

TIME FOR PAYMENT OF CLAIM

Benefits payable under the Policy will be made immediately upon receipt of satisfactory written proof of loss, unless the Policy provides for periodic payments. Where the Policy provides for periodic payments, the benefits will accrue and be paid monthly, subject to satisfactory written proof of loss.

PAYMENT OF CLAIM

Benefits payable on account of the Insured Person's death will be made to the beneficiary. If no valid beneficiary has been designated, the Company will pay the Insured Person's estate, or at the option of the Company, to the following:

- **a.** the Insured Person's spouse, if living; otherwise
- **b.** the Insured Person's then living children, if any, equally; otherwise
- **c.** the Insured Person's surviving parent(s), equally; otherwise
- **d.** the Insured Person's surviving brothers and/or sisters, equally.

If any indemnity of this Policy shall be payable to an estate of the Insured Person, or to the Insured Person or beneficiary who is a minor or otherwise unable to give a valid release, the Company may pay such indemnity, up to an amount not exceeding $1,000, to any relative by blood or by marriage of the Insured Person or beneficiary who is deemed by the Company to be equitably entitled thereto. Payment in accordance with this paragraph will release the Company from all liability hereunder for any amount so paid.

The death benefits provided hereunder shall not be assigned, transferred, or encumbered, and to the extent permitted by law will be exempt from attachment and otherwise free from the claims of creditors of the Insured Person or beneficiary.

All other indemnities of the Policy are payable to the Insured Person.

All or any portion of any indemnities provided by the policy on account of hospital, nursing, medical or surgical services may, at the Company's option be paid directly to the Hospital or other person rendering such services; but it is not required that the service be rendered by a particular Hospital or person. Any payment made by the Company in good faith pursuant to this provision will fully discharge the Company's obligation to the extent of the payment.

REIMBURSEMENT OF CLAIMS

The Company shall reimburse all claims or any portion of any claim from an insured or an insured's assignee, for payment under the policy, within 60 days after receipt of the claim by the Company. If a claim or a portion of a

REIMBURSEMENT OF CLAIMS (continued)

claim is contested by the Company, the insured or the insured's assignee shall be notified in writing within 45 days after receipt of the claim by the Company, that the claims is contested or denied; except that, the uncontested portion of the claim shall be paid within 60 days after receipt of the claim by the Company. The notice that a claim is contested will identify the contested portion of the claim and the reasons for contesting the claim.

The Company, upon receipt of the additional information requested from the insured or the insured's assignee, will pay or deny the contested claim or portion of the contested claim, within 90 days.

Payment will be treated as being made on the date a check is placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery.

CONTRACT

The entire contract between the Company and the Policyholder consists of the Policy, the application of the Policyholder, and the applications, if any, of the Insured Persons all of which shall be attached to the Policy when issued. All statements contained in the applications will be deemed representations and not warranties. No statement made by an applicant for insurance will be used to void the insurance or reduce the benefits, unless contained in a written application signed by the applicant. No agent has the authority to make or modify the policy, or to extend the time for payment of premiums, or to waive any of the Company's rights or requirements.

No changes to the Policy will be valid unless approved by an officer of the Company and evidenced an endorsement on the Policy or amendment of the Policy, signed by the Policyholder and the Company.

TITLES OR HEADINGS

The titles or headings used in the Policy are intended for reference only. They are not intended and will not be construed to be a substantive part of the Policy. They will not affect the validity, construction or effect of the Policy provisions.

PHYSICAL EXAMINATION AND AUTOPSY

The Company, at its own expense, will have the right and opportunity to examine an Insured Person, when and as often as may be reasonably required during the pendency of a claim under the Policy and to make an autopsy in the case of death, where it is not forbidden by law.

LEGAL ACTION

No action at law or in equity may be brought to recover on the policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action may be brought after the expiration of three (3) years after the time of written proof of loss is required to be furnished.

CONFORMITY WITH STATE STATUTES

Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which it is delivered is hereby amended to conform to the minimum requirements of those statutes.

ASSIGNMENT

No assignment of the Policy, or any part of it, will be binding on the Company unless approved in writing by the President or Vice President, and Secretary of the Company. The Company does not assume any responsibility for the validity of any assignment.

OTHER INSURANCE WITH THIS INSURER

If an Insured Person is covered by other insurance issued by the Company which:

a. duplicates any coverage of the Policy; and

b. is not subject to the Coordination of Benefits or Excess provisions of this Policy,

then the Insured Person (or his or her beneficiary) will elect the coverage of one policy. The Company will then return all premiums paid for the Insured Person's coverage under all other policies not paying benefits because of this paragraph.