CSURMA Athletic Injury Medical Expense (AIME) Committee Meeting Agenda
"This is an Open Public Meeting"

In accordance with the requirements of the Bagley-Keene Open Meeting Act, notice of this meeting must be posted in publicly accessible places, including the Internet, at least ten (10) days in advance of the meeting.

Per Government Code section 54954.2, persons requesting disability-related modifications or accommodations, including auxiliary aids or services in order to participate in the meeting, are requested to contact Alliant at (415) 403-1400 twenty-four hours in advance of the meeting. Entrance to the meeting location requires routine provision of identification to building security. However, CSURMA does not require any member of the public to register his or her name or to provide other information, as a condition to attendance at any public meeting and will not inquire of building security concerning information so provided. See Government Code section 54953.3.

Date & Time:	January 21, 2025 – 9:00 AM to 10:30 AM
Virtual Location:	Virtual Meeting (Zoom) Video Chat: https://alliantinsurance.zoom.us/96773363076 Teleconference: 1-669-900-6833 Meeting Number: 967 7336 3076 Passcode: 337667

A. General Administration

1.	**Appointment of Committee Member** The Committee will be asked to approve the appointments of Keyonda Kendall, filling Tina Tubb's seat on the Committee.	**A**	*Pg. 1*
2.	**Review of the Meeting Minutes – October 28, 2024** The Committee will receive a report on the minutes from their last meeting.	**A**	*Pg. 2*
3.	**AIME Loss Reports and Claim Trends** The Committee will receive a summary report from Health Special Risk, of the program's claims experience and trends.	**I**	*Pg. 8*
4.	**CSURMA Executive Committee Report** The Committee will receive a verbal report from the Executive Committee Liaison.	I	*Pg. 21*
5.	**NCAA Post Eligibility Insurance Program** The Committee will discuss the NCAA post eligibility insurance program procedures, effective August 1, 2024.	I	*Pg. 22*
6.	**CSURMA Plan of Benefits** The Committee will receive a report on the CSURMA Plan of Benefits.	I	*Pg. 48*
7.	**Retained Funds Analysis at June 30, 2024** The Committee will receive a report on the reserve fund analysis.	I	*Pg. 82*

8.	**Availity Medical Database Demonstration** The Committee will receive a demonstration of a medical billing, document retrieval, report generating, plus many other benefit demonstration.	I	*Pg. 85*
9.	**CSURMA Quarterly Report Ending September 30, 2024** This is provided as the latest approved Quarterly Report and reviewed by the AIME Committee at its October 28th meeting.	I	*Pg. 86*
10.	**CSURMA Athletes Newsletter** The Committee will receive a report on the CSURMA Athletes Newsletter.	I	*Pg. 88*
11.	**CSURMA AIME Committee Member and Staff Contact Lists** The Committee will be asked to review the contact list and provide updates as applicable.	I	*Pg. 89*

B. Adjournment

The next CSURMA Athletic Committee meeting is scheduled to meet on May 12, 2025. If you have questions regarding the agenda package, please contact *Stacey Weeks – sweeks@alliant.com (415) 403-1448.*

A Public Entity Joint Powers Authority

c/o Alliant Insurance Services, Inc. • 560 Mission Street, 6th Floor, San Francisco, CA 94105 • Phone: 415-403-1400 Fax: 415-402-0773

Agenda Item A1
CSURMA AIME Committee
Meeting Date: January 21, 2025

APPOINTMENT OF COMMITTEE MEMBER

ISSUE: The Committee will be asked to appoint Keyonda Kendall to replace Tina Tubbs on the Committee, effective January 1, 2025 – June 30, 2025.

RECOMMENDATION: The Committee will be asked to discuss and approve the appointment of Keyonda Kendall to fill Tina Tubbs' seat on the Committee.

FISCAL IMPACT: None

BACKGROUND: AIME Committee members serve two-year terms. The goal of staggering the seat elections is to maintain continuity, so that AIME benefits from the expertise Committee members develop during their terms. The AIME Committee Chair serves a two-year term.

PUBLICATION: None

ATTACHMENT(S): None.

Agenda Item A2
CSURMA AIME Committee
Meeting Date: January 21, 2025

REVIEW OF THE MEETING MINUTES – OCTOBER 28, 2024

ISSUE: The Committee will be asked to review the meeting minutes from the October 28, 2024 meeting.

RECOMMENDATION: It is recommended that the Committee review the minutes from its October 28, 2024 meeting, making corrections as necessary.

FISCAL IMPACT: None.

BACKGROUND: None.

PUBLICATION: None.

ATTACHMENT(S):

a. CSURMA AIME Committee Meeting Minutes – October 28, 2024

MINUTES OF THE CSURMA
AIME COMMITTEE MEETING
OCTOBER 28, 2024
SAN FRANCISCO, CALIFORNIA

MEMBERS PRESENT

Kyle Burnett, CSU Fullerton (Zoom)
Kelli Eberlein, CSU Fresno (Zoom)
Cindy Goodmon, CSU Bakersfield (Zoom)
Jennifer Lupo-Northrup, CSU Los Angeles (Zoom)
Kristal Slover, CPSU, San Luis Obispo (Zoom)
Michael Thorpe, Risk Manager, CSU Chico (Zoom)
Tina Tubbs, CSU Sacramento (Zoom)
Michael Beatty, San Francisco State, EC Liaison (Zoom)

MEMBERS ABSENT

Jarrod Spanjer, CSU Long Beach

STAFF, GUESTS & CONSULTANTS

Keyonda Kendall, CSU Sacramento Insurance Specialist (Zoom)
Amy Lightner, Alliant Insurance Services (Zoom)
Mimi Long, Alliant Insurance Services (Zoom)
Cathy Ray, Health Special Risk (Zoom)
Van Rin, Alliant Insurance Services (Zoom)
Brandon Schall, Health Special Risk (Zoom)
Jody Van Leuven, Office of the Chancellor (Zoom)
Stacey Weeks, Alliant Insurance Services

A. CALL TO ORDER

The meeting was called to order at 9:02 a.m. by Staff.

A1. Appointment of Committee Member

The Committee approved the appointment of Susan Vollmerhausen, Sr. Associate AD to fill Cindy Goodmon's seat, who is retiring from CSU Bakersfield, December 2024. Susan's seat will be effective January 1, 2025 – July 1, 2025.

A2. Review Meeting of Minutes

The Committee reviewed the meeting minutes. Staff was directed to revise item A6. FY 24-25 AIME Program Deposits, paragraph one, to the following:

The Committee discussed the AIME program to provide benefits for injuries sustained during participation in supervised scheduled intercollegiate sports events of the participating CSU campus. Benefits are limited to injuries sustained during participation in regularly scheduled intercollegiate sports (play/practice) during the regular season for such sport and the supervised or customary activities within the scope of such sport. Coverage includes sports listed on the sports census from each campus. It is understood that from time-to-time coverage and/or general claim extensions can arise between the 104 consecutive week Plan of Benefits coverage period and the need for additional medical services.

A3. AIME Loss Reports and Claim Trends – TIME CERTAIN 10:00 a.m.

Brandon Schall reported the total claim paid year to date for the 2022-2023 policy year is the best year thus far, aside from 2020-21 COVID year. The last two years are the best years with campus discounts, increased focus at the campus level, and management assistance contributing to the success. Discounts remain at 27.6% – 31% and primary insurance consistently paying 60/40 of all claims. This is an indication of more athletes having primary coverage. Overall summary, losses are trending back to normal with consistency in the amounts paid. Campus discounts are taken first before applying any other discounts. The PPO discount network availability and utilization was explained. HSR also has a list of vendors/provides where each member has an agreement and utilizing these lists continue to be successful. Discussion regarding the appeals process with provider and conclusion is that the appeals process in uncommon.

There was a discussion regarding the services provided by HSR, where HSR communicated their commitment to the AIME program. From the discussion, HSR will provide an action plan moving forward, and the action plan will include portal training annually as well as two trainings before year end.

A4. CSURMA Executive Committee Report

Mike Beatty reported on the Executive Committee meetings of September 6, 2024 and October 26, 2024 as follows:

- Excess insurance FY 2025/26 renewals provided for a 4% increase cost increase to some campuses and other campuses may see a 4% cost decrease
- The general liability program provided for an assessment and IDL/NDI provided for a dividend
- New International Health Program was presented for F1/J1 VISA students incoming from international territory. Staff was directed to confirm whether or not international student athletes are included in this coverage program. Staff was directed to confirm whether or not dental coverage is included in the program.

A5. NCAA Post Eligibility Insurance Program

Effective August 1, 2024, the NCAA will offer member schools post-eligibility injury insurance coverage for student athletes. The coverage provides excess limit for post injuries and no deductible. The program is a two-year period (104 weeks) after student-athletes complete their college athletics experience and will cover athletically related injuries sustained during play/practice in qualifying intercollegiate sports. The Committee discussed the member school will be responsible for establishing record-keeping procedures to document all intercollegiate athletic injuries. Members are also responsible for retaining documentation of injuries until the benefit period (104 weeks) is exhausted. The post eligibility insurance provides for $90,000 coverage with a zero deductible for two years/104 weeks, for related injuries for two years after the student separates from the school.

A5. CSURMA Plan of Benefits

The Committee revised Plan of Benefits of January 2016. Staff discussed the highlighted coverage benefits not found in the NCAA policy. The goal of the Plan of Benefits is to mirror the NCAA policy and provide secondary coverage up to the $90,000 NCAA limit (deductible). The comparison of benefits was with the NCAA Summary of Coverage and not the NCAA policy. The Committee discussed the number of chiropractic visits in the Plan of Benefits compared to the NCAA policy. Staff will develop a utilization report by campus and report back to the Committee. Staff requested a copy of the NCAA policy to better compare the Plan of Benefits to the NCAA policy. Once NCAA policy is received Staff will compare to the Plan of Benefits and be prepared to discuss at the next Committee meeting.

A6. Fiscal Year 2025/26 AIME Program Deposits

The total AIME coverage program costs are allocated to each member based on its percentage of the total claims for a five-year period. Mimi explained the FY 24/25 vs. the proposed FY 25/26 program. If a member's program costs decreased, it's because their five-year claim total decreased. If costs increased, it's because claims have improved. The rating calculation only uses actual claim payment within each fiscal year, regardless of the date of injury.

Mimi discussed the difference of the claims paid amounts to what is used to calculate the proposed FY 25/26 premiums and the loss reports the member has access to on-line, via the HSR database. Not all claims are paid in the same year of the date of loss. The outstanding liabilities are what the actuary believes will be additional claim payments on open claims as well as claims that have not yet been filed.

The Committee discussed at length the five-year claims paid and when payment is made and accounted for in using the five-year claim paid average. Program contributions are calculated using the actuarial report and the financial statements fiscal year ending June 2024.

A7. Retained Funds Analysis at June 30, 2024

The Committee discussed the calculation of the fund analysis. To assure the long-term financial strength of the program, and in recognition of the high degree of uncertainty in actuarial estimated due to inconsistent or inaccurate case reserving, the goal for retained funds was established to guide the Committee in making decisions regarding funding. Historically, if excess funding, only 50% of the maximum available excess funds is released.

A discussion for the allocation of the dividend if approved. Each campus receives an allocated portion of the dividend based on the percentage of their total five year premium deposits. The decision on how to apply the AIME dividend is made by each members' VP/CEO and does not go directly to the athletics department. Staff was directed to develop a dividend allocation summary and present at the Committee's January 2025 meeting.

A8. Renewal of Travel Accident Insurance

AIME purchases Travel Accident insurance to augment its self-insurance risk pool for AIME. The AIME Travel Accident policy renews December 31, 2024. Staff is in discussions with the Travel Accident underwriter to renew the policy with the same terms and conditions as the FY 2023/24 and paying the full premium, without the policy being audible. Staff requested a flat premium renewal for the 2024/25 renewal.

A9. CSURMA Plan of Benefits

The Committee discussed the AIME program provides benefits for injuries sustained during participation in regularly scheduled intercollegiate sports events of the participating CSU campus. Benefits are limited to injuries sustain during play/practice during the regular season for supervised or customary activities within the scope of such sport. Coverage includes sports listed on the sports census from each campus. It is understood that from time-to-time coverage and/or general claim extensions can arise between the 104 consecutive week Plan of Benefits coverage period and the need for additional medical services.

Staff requested the Committee to obtain a copy of the current FY NCAA policy, for Staff to prepare a comprehensive comparison of the Plan of Benefits and the NCAA policy.

A10. AIME Committee Nominations and Elections

Today, the Committee appointed Susan Vollmerhausen, to replace Cindy Goodmon, who is retiring December 2024 from CSU Bakersfield. In addition, Tina Tubbs, Sacramento State is requesting the Committee at its January 2025 meeting to appoint Keyonda Kendall, Student-Athlete Insurance Coordinator at Sacramento State, to replace Tina.

Keyonda discussed briefly the Availity database used by Sacramento State. Keyonda will provide a demonstration of the Availity database at the Committee's January 2025 meeting.

A11. Review of CSURMA AIME 2025 Calendar

The Committee reviewed its proposed 2025 meeting calendar, with revisions as follows:

- January 21, 2025
- May 12, 2025
- October 27, 2025

At this time all meetings will be conducted via Zoom.

A12. CSURMA Quarterly Report Ending September 30, 2024

The September 30, 2024 quarterly report was provided as this was last financial report approved by the Executive Committee. The Executive Committee emphasized that the program runs stable, is well funded, and meets the actuary recommendations.

A13. CSURMA Athletes Newsletter

The Committee discussed the draft CSURMA Athletes Newsletter. Staff was directed to include the following in the upcoming newsletter:

- AIME Plan of Benefits
- AIME student athlete extension of benefits procedure
- AIME coverage for Cheer/Dance teams
- Other than AIME coverage for Cheer/Dance teams
- NCAA Post Eligibility insurance – effective August 1, 2024

A14. CSURMA Committee Member and Staff Contact Lists

Staff was asked to provide updates to contact information to Staff.

B. ADJOURNMENT

The meeting was adjourned at 12:10 p.m.

Agenda Item A3
CSURMA AIME Committee
Meeting Date: January 21, 2025

AIME LOSS REPORTS AND CLAIM TRENDS

ISSUE: The Committee will hear a report from Health Special Risk (HSR), the Claims Administrator on loss experience and claim trends for the period beginning July 1, 2015.

RECOMMENDATION: No action is requested.

FISCAL IMPACT: Information Item only.

BACKGROUND: HSR provides third party claims administration. Effective July 1, 2015

PUBLICATION: None

ATTACHMENT(S):

a. Monthly Claims Payment Summaries by Campus/Paid at December 31, 2024

HSR
ACCIDENT INSURANCE SOLUTIONS

csurma California State University Risk Management Authority

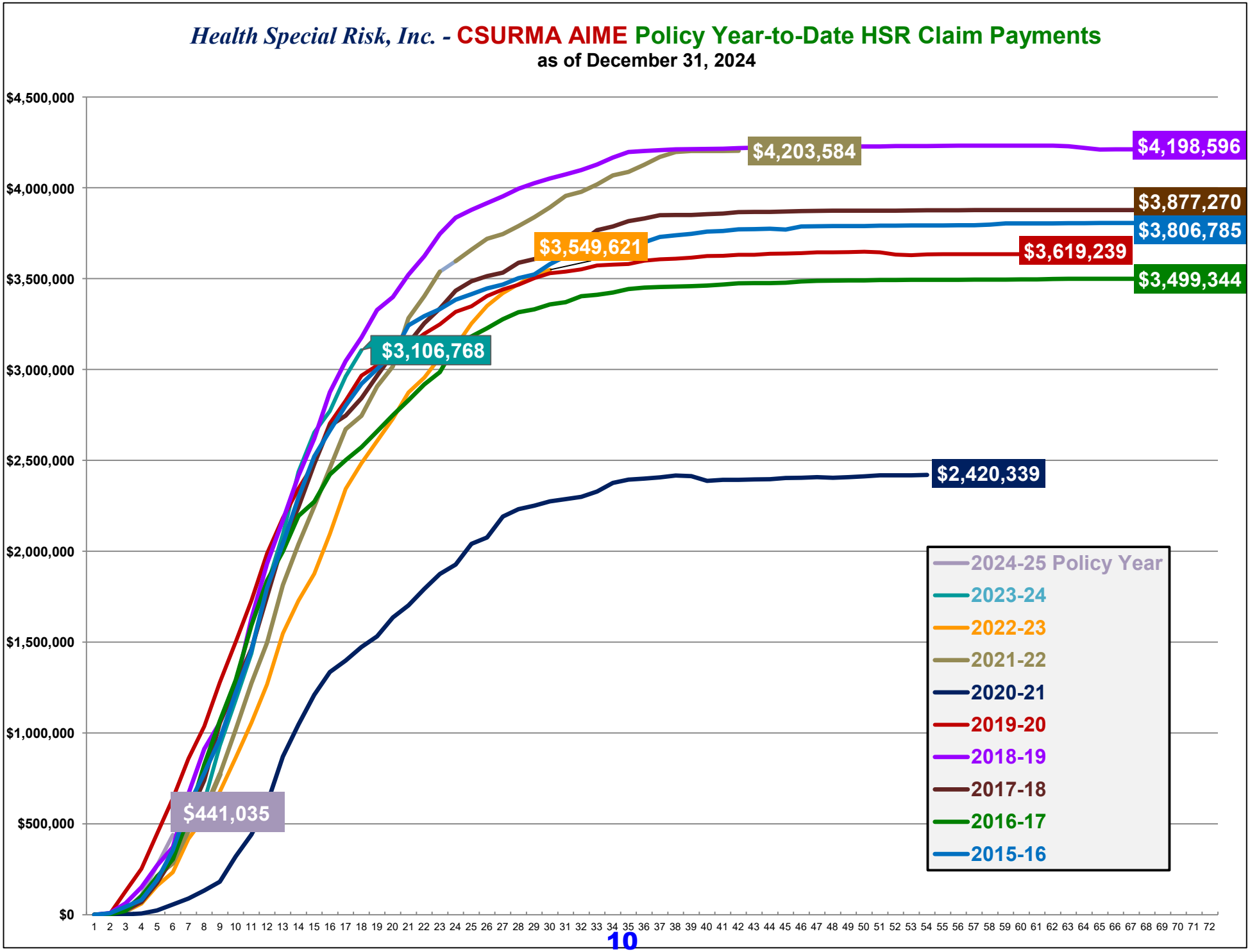
ATHLETIC INJURY MEDICAL EXPENSE PROGRAM (AIME)

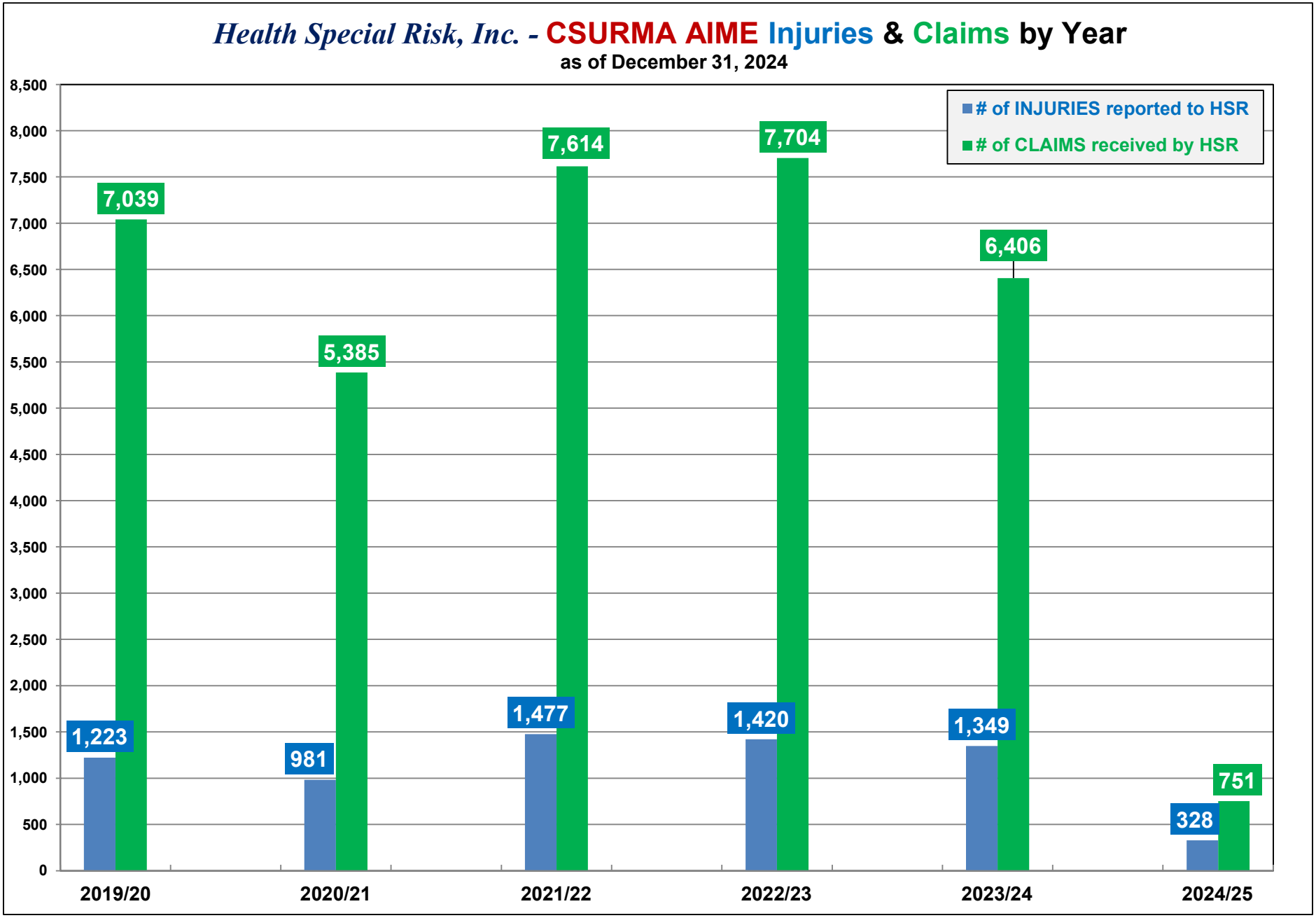
Health Special Risk, Inc.

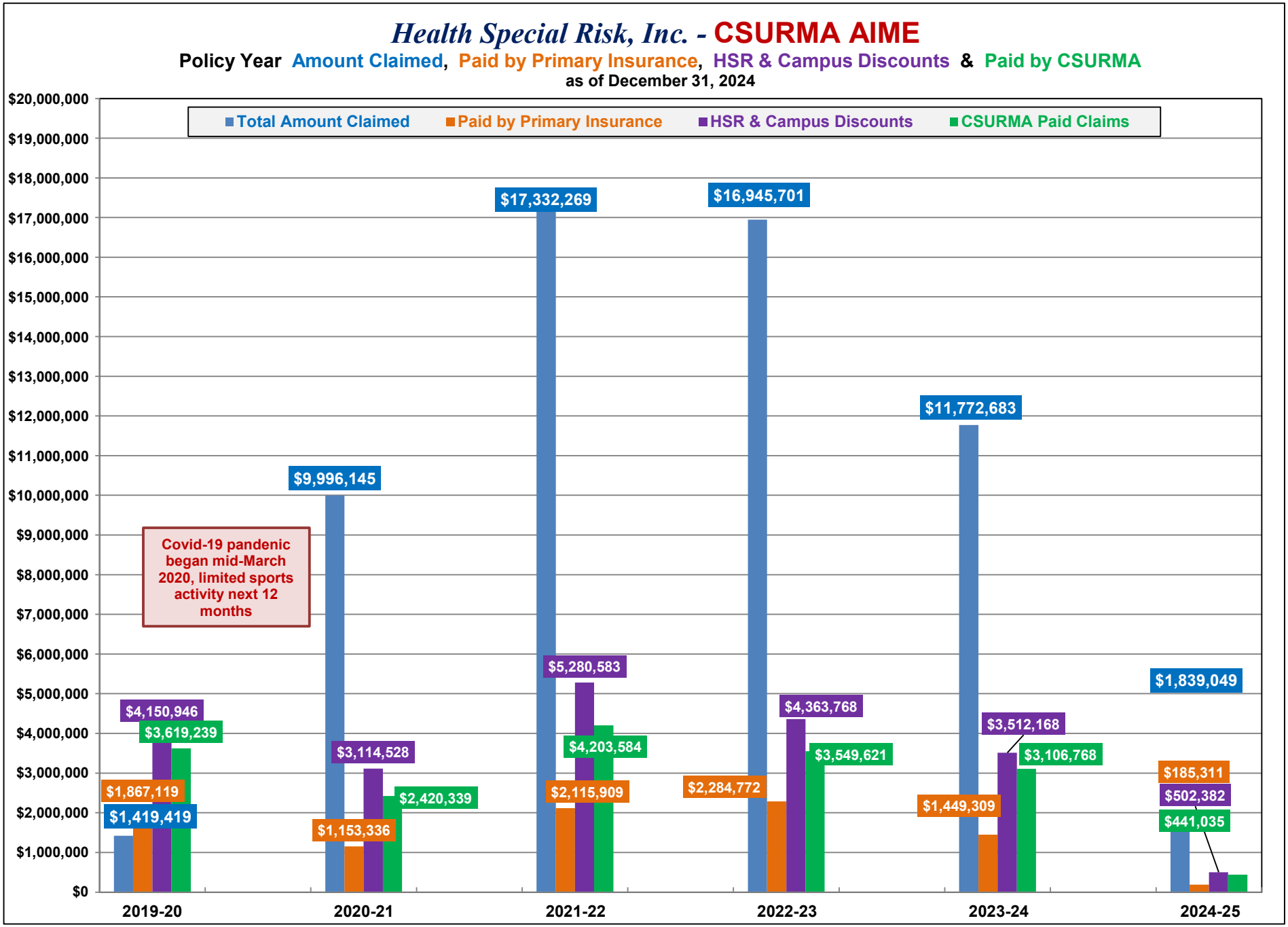
AIME Loss Reports
as of December 31, 2024

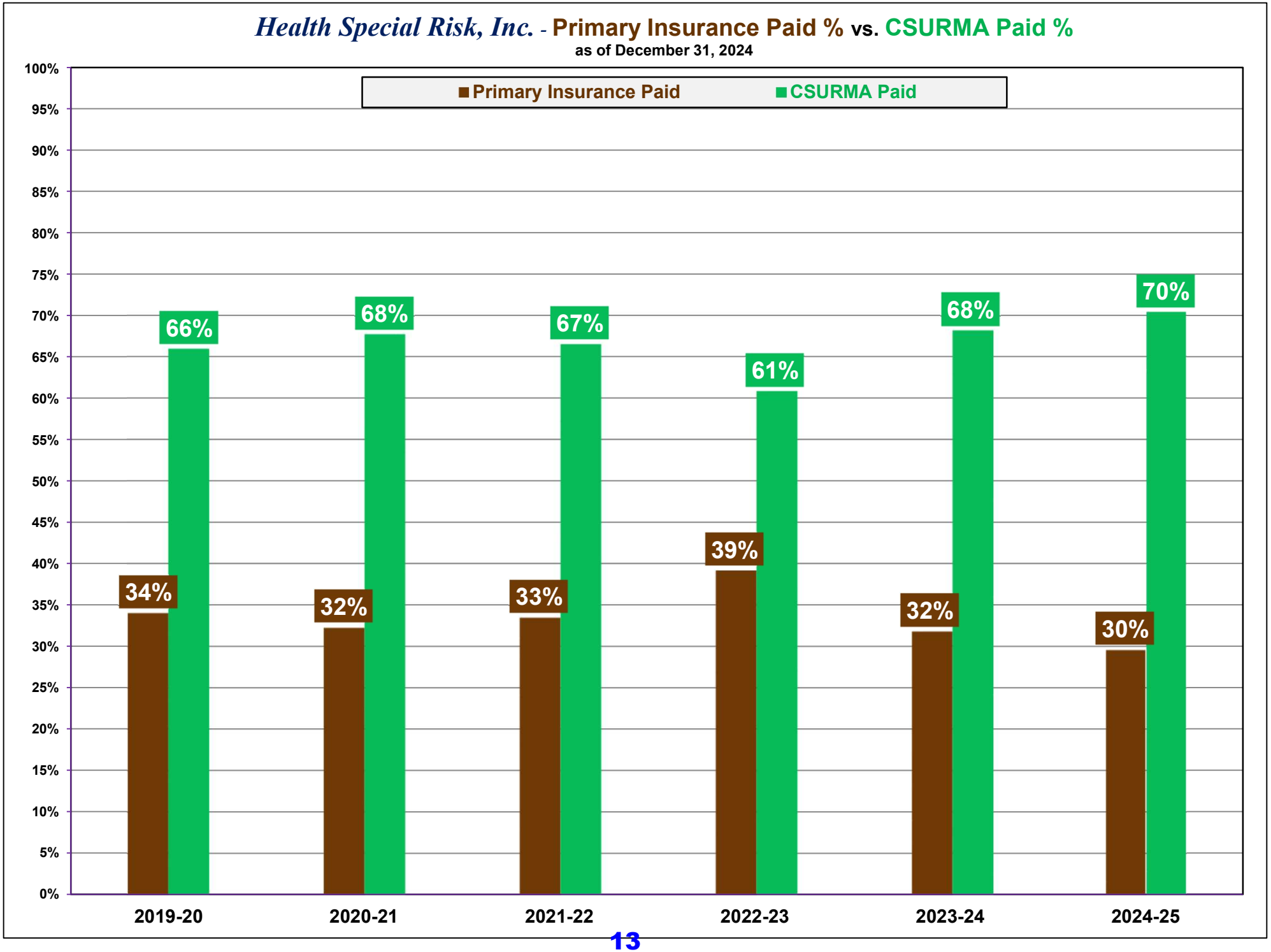
January 21, 2025 AIME Committee Meeting

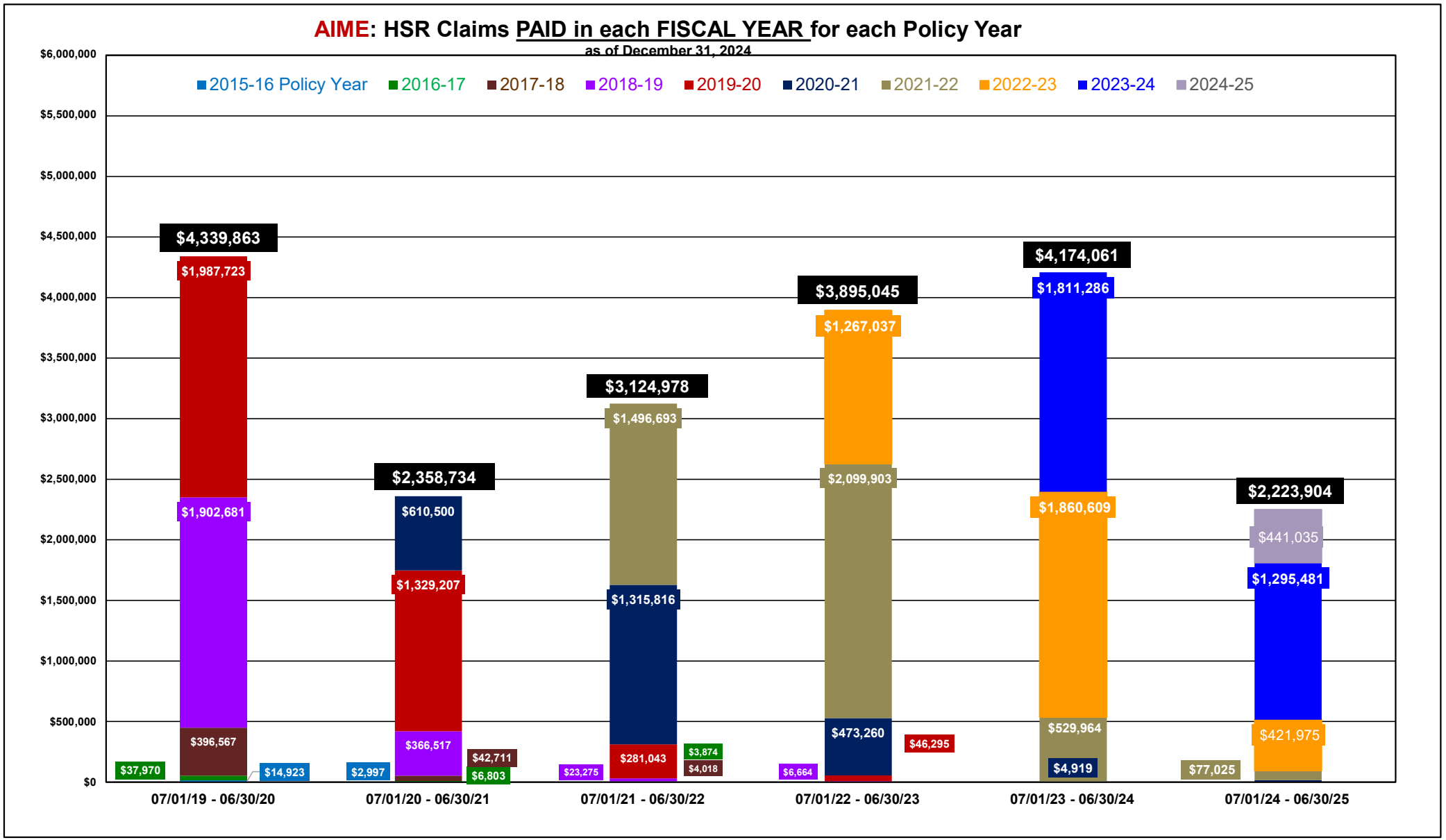
Brandon Schall, President
Cathy Ray, Sr. Vice President & Chief Claims Officer


Health Special Risk, Inc. - CSURMA AIME Policy Year-to-Date HSR Claim Payments
as of December 31, 2024
$4,500,000
$4,000,000
$3,500,000
$3,000,000
$2,500,000
$2,000,000
$1,500,000
$1,000,000
$500,000
$0
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72
$4,203,584
$4,198,596
$3,877,270
$3,806,785
$3,549,621
$3,619,239
$3,499,344
$3,106,768
$2,420,339
$441,035
2024-25 Policy Year
2023-24
2022-23
2021-22
2020-21
2019-20
2018-19
2017-18
2016-17
2015-16


Health Special Risk, Inc. - CSURMA AIME Injuries & Claims by Year
as of December 31, 2024
# of INJURIES reported to HSR
# of CLAIMS received by HSR
8,500
8,000
7,500
7,000
6,500
6,000
5,500
5,000
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
7,039
5,385
7,614
7,704
6,406
751
1,223
981
1,477
1,420
1,349
328
2019/20
2020/21
2021/22
2022/23
2023/24
2024/25


Health Special Risk, Inc. - CSURMA AIME
Policy Year Amount Claimed, Paid by Primary Insurance, HSR & Campus Discounts & Paid by CSURMA
as of December 31, 2024
Total Amount Claimed
Paid by Primary Insurance
HSR & Campus Discounts
CSURMA Paid Claims
$20,000,000
$19,000,000
$18,000,000
$17,000,000
$16,000,000
$15,000,000
$14,000,000
$13,000,000
$12,000,000
$11,000,000
$10,000,000
$9,000,000
$8,000,000
$7,000,000
$6,000,000
$5,000,000
$4,000,000
$3,000,000
$2,000,000
$1,000,000
$0
Covid-19 pandenic began mid-March 2020, limited sports activity next 12 months
$1,419,419
$1,867,119
$4,150,946
$3,619,239
$9,996,145
$1,153,336
$3,114,528
$2,420,339
$17,332,269
$2,115,909
$5,280,583
$4,203,584
$16,945,701
$2,284,772
$4,363,768
$3,549,621
$11,772,683
$1,449,309
$3,512,168
$3,106,768
$1,839,049
$185,311
$502,382
$441,035
2019-20
2020-21
2021-22
2022-23
2023-24
2024-25


Health Special Risk, Inc. - Primary Insurance Paid % vs. CSURMA Paid %
as of December 31, 2024
Primary Insurance Paid
CSURMA Paid
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
34%
66%
32%
68%
33%
67%
39%
61%
32%
68%
30%
70%
2019-20
2020-21
2021-22
2022-23
2023-24
2024-25


AIME: HSR Claims PAID in each FISCAL YEAR for each Policy Year
as of December 31, 2024
2015-16 Policy Year
2016-17
2017-18
2018-19
2019-20
2020-21
2021-22
2022-23
2023-24
2024-25
$6,000,000
$5,500,000
$5,000,000
$4,500,000
$4,000,000
$3,500,000
$3,000,000
$2,500,000
$2,000,000
$1,500,000
$1,000,000
$500,000
$0
$4,339,863
$1,987,723
$1,902,681
$396,567
$37,970
$14,923
$2,358,734
$610,500
$1,329,207
$366,517
$42,711
$6,803
$2,997
$3,124,978
$1,496,693
$1,315,816
$281,043
$3,874
$4,018
$23,275
$3,895,045
$1,267,037
$2,099,903
$473,260
$46,295
$6,664
$4,174,061
$1,811,286
$1,860,609
$529,964
$4,919
$2,223,904
$441,035
$1,295,481
$421,975
$77,025
07/01/19 - 06/30/20
07/01/20 - 06/30/21
07/01/21 - 06/30/22
07/01/22 - 06/30/23
07/01/23 - 06/30/24
07/01/24 - 06/30/25

HSR
ACCIDENT INSURANCE SOLUTIONS

CSURMA CLAIMS PAID ANALYSIS
Year # 10: 2024/2025 Policy Year

csurma
California State University Risk Management Authority

CSU Campus	# of Injuries	# of Claims	# Injuries w Primary Insurance payments	% of Total Injuries	Total Amount Claimed	Primary Insurance Payment	CSU Campus Discount	HSR PPO Discounts	HSR Payments
CALIFORNIA MARITIME ACADEMY	2	6	2	100%	$3,162	$672	$0	$0	**$826**
CSPU, POMONA	12	34	2	17%	$79,208	$180	$5,846	$45,752	**$26,167**
CSPU, SAN LUIS OBISPO	31	74	24	77%	$52,836	$12,755	$198	$5,585	**$15,058**
CSU, BAKERSFIELD	21	56	13	62%	$103,442	$17,769	$0	$12,327	**$22,867**
CSU, DOMINGUEZ HILLS	2	4	1	50%	$5,795	$0	$0	$0	**$4,735**
CSU, EAST BAY	3	4	3	100%	$3,679	$620	$0	$740	**$692**
CSU, FRESNO	61	108	22	36%	$311,111	$5,050	$204,773	$965	**$72,210**
CSU, FULLERTON	10	23	3	30%	$17,152	$668	$0	$4,293	**$5,319**
CSU, LONG BEACH	48	134	12	25%	$113,685	$5,847	$16,845	$3,415	**$49,767**
CSU, MONTEREY BAY	13	24	12	92%	$16,021	$3,861	$0	$1,934	**$4,544**
CSU, NORTHRIDGE	8	9	3	38%	$4,241	$270	$0	$477	**$2,166**
CSU, SACRAMENTO	16	46	6	38%	$677,203	$99,110	$9,440	$76,794	**$125,327**
CSU, SAN BERNARDINO	2	4	1	50%	$95,495	$1,859	$0	$72,469	**$21,167**
CSU, SAN MARCOS	4	13	4	100%	$13,791	$1,242	$0	$0	**$4,185**
CSU, STANISLAUS	5	8	0	0%	$5,495	$0	$79	$2,313	**$3,103**
HUMBOLDT STATE UNIVERSITY	5	12	2	40%	$9,454	$2,064	$0	$380	**$2,689**
SAN DIEGO STATE UNIVERSITY	64	135	26	41%	$217,890	$17,097	$19,377	$10,716	**$61,559**
SAN JOSE STATE UNIVERSITY	19	54	14	74%	$47,535	$6,140	$0	$7,665	**$16,027**
SONOMA STATE UNIVERSITY	2	3	2	100%	$61,854	$10,108	$0	$0	**$2,629**
Totals:	**328**	**751**	**152**	**46%**	**$1,839,049**	**$185,311**	**$256,557**	**$245,825**	**$441,035**

HSR
ACCIDENT INSURANCE SOLUTIONS

CSURMA CLAIMS PAID ANALYSIS
Year # 9: 2023/2024 Policy Year

csurma
California State University Risk Management Authority

CSU Campus	# of Injuries	# of Claims	# Injuries w Primary Insurance payments	% of Total Injuries	Total Amount Claimed	Primary Insurance Payment	CSU Campus Discount	HSR PPO Discounts	HSR Payments
CALIFORNIA MARITIME ACADEMY	4	49	3	75%	$43,805	$16,030	$0	$605	**$4,878**
CSPU, POMONA	67	386	17	25%	$1,054,779	$6,635	$53,728	$643,665	**$329,067**
CSPU, SAN LUIS OBISPO	121	881	86	71%	$1,097,576	$127,743	$577	$240,088	**$314,696**
CSU, BAKERSFIELD	85	442	53	62%	$825,854	$136,760	$0	$209,062	**$157,841**
CSU, CHICO	8	64	7	88%	$216,614	$40,592	$0	$54,707	**$33,972**
CSU, DOMINGUEZ HILLS	13	81	9	69%	$296,199	$20,929	$26,942	$10,451	**$156,986**
CSU, EAST BAY	35	151	27	77%	$325,871	$73,180	$63	$18,958	**$53,156**
CSU, FRESNO	223	679	93	42%	$1,470,520	$90,016	$484,290	$161,764	**$342,863**
CSU, FULLERTON	101	351	45	45%	$739,307	$84,996	$0	$222,375	**$185,599**
CSU, LONG BEACH	151	982	85	56%	$1,216,241	$149,423	$240,409	$64,355	**$366,301**
CSU, LOS ANGELES	8	92	4	50%	$114,098	$1,589	$8,519	$45,812	**$54,300**
CSU, MONTEREY BAY	31	138	23	74%	$247,214	$38,426	$8	$90,900	**$69,725**
CSU, NORTHRIDGE	47	311	27	57%	$513,348	$61,028	$38,812	$66,315	**$141,155**
CSU, SACRAMENTO	97	331	53	55%	$1,127,996	$277,027	$98,633	$62,096	**$186,839**
CSU, SAN BERNARDINO	7	26	2	29%	$29,159	$2,825	$0	$7,285	**$10,236**
CSU, SAN MARCOS	15	33	13	87%	$128,556	$76,628	$513	$2,087	**$16,536**
CSU, STANISLAUS	36	127	23	64%	$292,988	$27,108	$17,204	$7,395	**$112,420**
HUMBOLDT STATE UNIVERSITY	15	71	13	87%	$109,474	$25,476	$0	$5,006	**$16,867**
SAN DIEGO STATE UNIVERSITY	143	405	64	45%	$948,356	$87,965	$234,023	$86,856	**$232,857**
SAN FRANCISCO STATE UNIVERSITY	7	22	4	57%	$109,476	$27,988	$434	$0	**$16,875**
SAN JOSE STATE UNIVERSITY	125	738	83	66%	$810,887	$64,556	$67,297	$232,868	**$277,992**
SONOMA STATE UNIVERSITY	10	46	8	80%	$54,367	$12,390	$0	$8,068	**$25,606**
Totals:	**1,349**	**6,406**	**742**	**55%**	**$11,772,683**	**$1,449,309**	**$1,271,451**	**$2,240,717**	**$3,106,768**

HSR
ACCIDENT INSURANCE SOLUTIONS

CSURMA CLAIMS PAID ANALYSIS
Year # 8: 2022/2023 Policy Year

csurma
California State University Risk Management Authority

CSU Campus	# of Injuries	# of Claims	# Injuries w Primary Insurance payments	% of Total Injuries	Total Amount Claimed	Primary Insurance Payment	CSU Campus Discount	HSR PPO Discounts	HSR Payments
CALIFORNIA MARITIME ACADEMY	10	55	10	100%	$164,284	$48,532	$0	$2,265	**$17,425**
CSPU, POMONA	51	274	28	55%	$481,137	$33,101	$35,672	$173,413	**$128,898**
CSPU, SAN LUIS OBISPO	163	1,247	111	68%	$1,906,281	$300,495	$787	$330,336	**$344,239**
CSU, BAKERSFIELD	55	294	41	75%	$679,812	$59,418	$1,307	$248,199	**$146,713**
CSU, CHICO	8	39	7	88%	$50,222	$11,861	$0	$2,241	**$11,312**
CSU, DOMINGUEZ HILLS	22	83	13	59%	$503,094	$86,995	$0	$102,146	**$134,233**
CSU, EAST BAY	33	171	29	88%	$385,615	$90,092	$22	$50,348	**$70,471**
CSU, FRESNO	248	873	118	48%	$1,998,298	$132,411	$646,745	$198,661	**$455,364**
CSU, FULLERTON	84	376	54	64%	$842,131	$103,084	$1,461	$240,395	**$241,374**
CSU, LONG BEACH	178	1,471	117	66%	$2,660,673	$278,297	$483,814	$105,848	**$468,724**
CSU, LOS ANGELES	12	73	8	67%	$101,348	$14,144	$13,906	$18,373	**$32,770**
CSU, MONTEREY BAY	27	133	21	78%	$159,054	$28,064	$0	$23,620	**$38,314**
CSU, NORTHRIDGE	64	270	34	53%	$649,492	$41,866	$57,967	$178,664	**$154,148**
CSU, SACRAMENTO	88	304	51	58%	$1,036,947	$237,249	$77,890	$127,749	**$152,074**
CSU, SAN BERNARDINO	13	46	7	54%	$160,383	$8,514	$0	$64,306	**$45,690**
CSU, SAN MARCOS	16	35	13	81%	$200,082	$47,354	$1,648	$0	**$28,845**
CSU, STANISLAUS	21	108	15	71%	$267,571	$103,203	$1,653	$9,352	**$26,092**
HUMBOLDT STATE UNIVERSITY	11	99	8	73%	$307,925	$74,241	$0	$20,230	**$37,016**
SAN DIEGO STATE UNIVERSITY	161	564	78	48%	$1,525,748	$161,096	$259,055	$210,988	**$343,555**
SAN FRANCISCO STATE UNIVERSITY	12	108	8	67%	$573,134	$178,309	$2,113	$100,748	**$67,628**
SAN JOSE STATE UNIVERSITY	123	964	76	62%	$1,859,361	$162,592	$191,470	$377,545	**$558,177**
SONOMA STATE UNIVERSITY	20	117	15	75%	$433,110	$83,855	$0	$2,830	**$46,558**
Totals:	**1,420**	**7,704**	**862**	**61%**	**$16,945,701**	**$2,284,772**	**$1,775,510**	**$2,588,258**	**$3,549,621**

HSR
ACCIDENT INSURANCE SOLUTIONS

CSURMA CLAIMS PAID ANALYSIS
Year # 7: 2021/2022 Policy Year

csurma
California State University Risk Management Authority

CSU Campus	# of Injuries	# of Claims	# Injuries w Primary Insurance payments	% of Total Injuries	Total Amount Claimed	Primary Insurance Payment	CSU Campus Discount	HSR PPO Discounts	HSR Payments
CALIFORNIA MARITIME ACADEMY	5	6	3	60%	$11,478	$6,821	$0	$1,174	**$1,904**
CSPU, POMONA	25	108	18	72%	$375,759	$38,130	$23,965	$48,891	**$49,234**
CSPU, SAN LUIS OBISPO	186	1,207	125	67%	$2,510,833	$286,009	$2,294	$508,026	**$589,271**
CSU, BAKERSFIELD	63	412	41	65%	$938,749	$115,455	$4,963	$194,433	**$197,734**
CSU, CHICO	14	104	12	86%	$168,794	$25,486	$200	$38,478	**$44,325**
CSU, DOMINGUEZ HILLS	9	52	7	78%	$237,171	$9,163	$18,572	$68,559	**$85,194**
CSU, EAST BAY	17	87	17	100%	$153,225	$29,530	$135	$485	**$24,135**
CSU, FRESNO	257	887	131	51%	$2,077,204	$187,061	$760,964	$157,167	**$405,197**
CSU, FULLERTON	85	374	48	56%	$794,795	$72,938	$46,277	$172,454	**$312,953**
CSU, LONG BEACH	216	1,336	111	51%	$2,345,815	$144,666	$852,364	$76,656	**$613,448**
CSU, LOS ANGELES	9	79	6	67%	$223,396	$12,334	$1,000	$11,748	**$44,591**
CSU, MONTEREY BAY	27	157	15	56%	$482,778	$27,412	$188	$216,179	**$117,191**
CSU, NORTHRIDGE	55	316	18	33%	$729,089	$12,033	$50,619	$315,818	**$237,944**
CSU, SACRAMENTO	118	645	66	56%	$1,105,373	$233,725	$96,474	$167,689	**$243,843**
CSU, SAN BERNARDINO	13	53	7	54%	$152,727	$3,143	$334	$73,285	**$50,638**
CSU, SAN MARCOS	22	50	20	91%	$248,810	$140,043	$0	$0	**$31,056**
CSU, STANISLAUS	32	196	17	53%	$268,027	$40,193	$473	$48,751	**$51,222**
HUMBOLDT STATE UNIVERSITY	11	96	7	64%	$173,043	$46,112	$56	$4,512	**$30,476**
SAN DIEGO STATE UNIVERSITY	120	453	62	52%	$1,421,875	$151,651	$197,851	$243,072	**$361,268**
SAN FRANCISCO STATE UNIVERSITY	11	42	7	64%	$399,716	$228,687	$639	$829	**$18,137**
SAN JOSE STATE UNIVERSITY	162	828	96	59%	$2,266,819	$278,334	$216,896	$615,764	**$625,130**
SONOMA STATE UNIVERSITY	20	126	19	95%	$246,794	$26,980	$0	$42,349	**$68,694**
Totals:	**1,477**	**7,614**	**853**	**58%**	**$17,332,269**	**$2,115,909**	**$2,274,264**	**$3,006,319**	**$4,203,584**

HSR
ACCIDENT INSURANCE SOLUTIONS

CSURMA CLAIMS PAID ANALYSIS
Year # 6: 2020/2021 Policy Year

csurma
California State University Risk Management Authority

CSU Campus	# of Injuries	# of Claims	# Injuries w Primary Insurance payments	% of Total Injuries	Total Amount Claimed	Primary Insurance Payment	CSU Campus Discount	HSR PPO Discounts	HSR Payments
CSPU, SAN LUIS OBISPO	135	940	100	74%	$1,305,401	$198,339	$882	$230,468	**$353,859**
CSU, BAKERSFIELD	36	208	21	58%	$339,951	$38,857	$1,248	$141,831	**$115,410**
CSU, CHICO	2	12	2	100%	$6,879	$3,590	$0	$0	**$528**
CSU, DOMINGUEZ HILLS	1	4	1	100%	$10,896	$2,385	$0	$0	**$1,175**
CSU, EAST BAY	4	23	3	75%	$62,641	$22,376	$0	$428	**$9,294**
CSU, FRESNO	200	995	99	50%	$1,896,666	$134,085	$723,774	$16,764	**$369,017**
CSU, FULLERTON	78	280	33	42%	$516,357	$50,580	$50,382	$122,960	**$134,555**
CSU, LONG BEACH	103	864	55	53%	$1,696,538	$75,649	$757,067	$57,150	**$414,948**
CSU, MONTEREY BAY	1	48	1	100%	$100,558	$11,160	$0	$0	**$1,413**
CSU, NORTHRIDGE	37	292	20	54%	$575,269	$38,463	$56,022	$81,961	**$165,874**
CSU, SACRAMENTO	130	650	70	54%	$823,971	$214,383	$93,983	$88,946	**$208,272**
CSU, SAN BERNARDINO	3	7	3	100%	$20,041	$2,326	$0	$0	**$2,678**
HUMBOLDT STATE UNIVERSITY	6	87	6	100%	$166,681	$41,944	$45	$0	**$25,084**
SAN DIEGO STATE UNIVERSITY	102	316	58	57%	$804,267	$89,384	$163,698	$33,781	**$176,981**
SAN JOSE STATE UNIVERSITY	135	630	54	40%	$1,646,265	$228,463	$190,239	$302,901	**$430,505**
SONOMA STATE UNIVERSITY	8	29	7	88%	$23,764	$1,352	$0	$0	**$10,744**
Totals:	**981**	**5,385**	**533**	**54%**	**$9,996,145**	**$1,153,336**	**$2,037,339**	**$1,077,189**	**$2,420,339**

HSR
ACCIDENT INSURANCE SOLUTIONS

CSURMA CLAIMS PAID ANALYSIS
Year # 5: 2019/2020 Policy Year

csurma
California State University Risk Management Authority

CSU Campus	# of Injuries	# of Claims	# Injuries w Primary Insurance payments	% of Total Injuries	Total Amount Claimed	Primary Insurance Payment	CSU Campus Discount	HSR PPO Discounts	HSR Payments
CALIFORNIA MARITIME ACADEMY	6	15	6	100%	$18,840	$6,608	$0	$0	**$3,421**
CSPU, POMONA	18	230	10	56%	$403,007	$37,443	$38,117	$89,564	**$63,237**
CSPU, SAN LUIS OBISPO	149	1,044	99	66%	$1,422,708	$280,335	$20,484	$209,394	**$315,312**
CSU, BAKERSFIELD	57	253	39	68%	$811,722	$117,926	$7,362	$145,075	**$166,428**
CSU, CHICO	7	61	5	71%	$106,752	$6,260	$0	$53,594	**$37,107**
CSU, DOMINGUEZ HILLS	16	182	4	25%	$254,040	$8,613	$0	$94,445	**$126,265**
CSU, EAST BAY	35	123	27	77%	$254,600	$56,395	$2,442	$10,382	**$42,331**
CSU, FRESNO	158	733	74	47%	$1,958,245	$81,859	$816,273	$61,933	**$441,223**
CSU, FULLERTON	77	431	43	56%	$839,063	$40,664	$8,119	$353,932	**$281,860**
CSU, LONG BEACH	138	1,065	75	54%	$1,585,557	$155,710	$309,037	$62,829	**$459,246**
CSU, LOS ANGELES	6	23	3	50%	$66,745	$32,633	$0	$4,851	**$7,340**
CSU, MONTEREY BAY	35	119	24	69%	$158,638	$53,110	$1,390	$8,059	**$36,244**
CSU, NORTHRIDGE	60	344	25	42%	$1,025,019	$88,349	$40,114	$384,268	**$288,368**
CSU, SACRAMENTO	121	819	65	54%	$1,716,716	$318,106	$257,470	$182,340	**$462,108**
CSU, SAN BERNARDINO	32	137	9	28%	$504,482	$16,025	$0	$234,290	**$172,487**
CSU, SAN MARCOS	18	62	13	72%	$37,617	$8,311	$713	$0	**$6,529**
CSU, STANISLAUS	20	107	16	80%	$93,355	$6,342	$4,395	$13,649	**$26,779**
HUMBOLDT STATE UNIVERSITY	1	1	1	100%	$3,628	$863	$0	$0	**$1,216**
SAN DIEGO STATE UNIVERSITY	129	496	55	43%	$1,367,590	$261,280	$221,963	$144,377	**$309,163**
SAN FRANCISCO STATE UNIVERSITY	11	20	7	64%	$135,283	$33,210	$185	$1,199	**$12,006**
SAN JOSE STATE UNIVERSITY	106	552	51	48%	$1,003,193	$140,624	$192,373	$134,611	**$285,185**
SONOMA STATE UNIVERSITY	23	222	20	87%	$427,360	$116,452	$16,417	$25,300	**$75,385**
Totals:	**1,223**	**7,039**	**671**	**55%**	**$14,194,159**	**$1,867,119**	**$1,936,853**	**$2,214,093**	**$3,619,239**

Agenda Item A4
CSURMA AIME Committee
Meeting Date: January 21, 2025

CSURMA EXECUTIVE COMMITTEE REPORT

ISSUE: The AIME Committee will receive a report from the CSURMA Executive Committee Liaison, Michael Beatty, regarding the Executive Committee's January 13, 2025 meeting.

RECOMMENDATION: This is an information item only; no action is required.

FISCAL IMPACT: None.

BACKGROUND: Michael Beatty, San Francisco State, is the Executive Committee Liaison for AIME.

PUBLICATION: None.

ATTACHMENT(S): None.

Agenda Item A5
CSURMA AIME Committee
Meeting Date: January 21, 2025

NCAA POST ELIGIBILITY INSURANCE PROGRAM

ISSUE: The NCAA Post Eligibility Insurance Program became effective August 1, 2024. The program is a way the NCAA can support student-athletes beyond their playing days. The Committee will receive additional information regarding the program for discussion at today's meeting.

RECOMMENDATION: This item is for information only; no action is requested.

FISCAL IMPACT: None.

BACKGROUND: The Post-Eligibility Insurance Program was announced by the Board of Governors in August 2023 as part of the effort to modernize NCAA rules and support the holistic student-athlete model. The program is a way the NCAA can support student-athletes beyond their playing days.

Preliminary information on the program was sent to the NCAA membership. For up to two years (104 weeks) after student-athletes separate from their NCAA member school, the program will cover medical expenses for athletically related injuries sustained during participation in an NCAA qualifying intercollegiate sport (includes emerging sports). The program will become active Aug. 1, 2024, and will provide excess insurance coverage for properly documented injuries that occur on or after this date. The program will be available to all student-athletes at all institutions in all divisions.

PUBLICATION: None.

ATTACHMENT(S):

a. NCAA Post Eligibility Ins Prog Overview – July 2024
b. NCAA Post-Eligibility Ins Summary – Information
c. NCAA's New Post-Eligibility Excess Ins Prog – Two Years After Separation - Lexology
d. Post Eligibility Insurance Program Document
e. Post Eligibility Ins Prog Incident Report Form
f. PEI Description of Covered Expenses
g. PEI Benefit Period Decision Tree
h. PEI Member-Institution Guide

NCAA Post-Eligibility Insurance Program

Overview

Updated July 2024

This is a general summary of the NCAA Post-Eligibility Insurance Program. The policy contains all of the provisions, exclusions and qualifications of the insurance benefits. If any discrepancy exists between this summary and the policy, the policy will govern and control the payment of benefits.

INTRODUCTION TO THE NCAA POST-ELIGIBILITY INSURANCE PROGRAM

The NCAA sponsors a Post-Eligibility Insurance Program that begins Aug. 1, 2024. The Post-Eligibility Insurance Program is a way the NCAA can support student-athletes beyond their playing days. The program was announced by the Board of Governors in August 2023 as part of the effort to modernize NCAA rules.

For up to two years (104 weeks) after student-athletes separate from school or voluntarily withdraw* from athletics, the program covers accident medical expenses for athletically related injuries sustained during participation in an NCAA qualifying intercollegiate sport, including NCAA emerging sports. The program provides excess insurance coverage for properly documented covered injuries that occur on or after Aug. 1, 2024. The program is available to all student-athletes at all institutions in all divisions.

The coverage provides benefits in excess of any other valid and collectible insurance. The policy has a $90,000 excess limit per injury, with no deductible. Of the $90,000 available, up to $25,000 is available for mental health services related to an eligible, documented athletic injury.

Provided all eligibility criteria are met, the policy is triggered when a student-athlete's primary insurance coverage is exhausted or when primary insurance will not cover accident medical expenses covered under the post-eligibility program, subject to terms and conditions of the policy.

*Voluntarily withdraw means submission of a formal voluntary withdrawal form from the student-athlete with no intent to transfer to and resume intercollegiate sport/activities at another school.

ENROLLMENT

Student-athletes are automatically covered under the policy for those qualifying intercollegiate athletics injuries that meet both of the following conditions:

- Occur during the policy period (on or after Aug. 1, 2024).
- Are documented and on file with the institution's athletics department.

Student-athletes DO NOT need to opt in for coverage before an injury occurs. Those who transfer, are part- or full-time students, or are later deemed ineligible for NCAA competition would be covered under the policy, provided the eligibility criteria is met. International student-athletes also are covered under the program subject to the regulations of the athlete's country of origin.

Action is not required by the student-athlete unless the student-athlete needs to file a claim during the benefit period. Please visit www.posteligibilityinsurance.com for more information on filing a claim.

This is a general summary of the NCAA Post-Eligibility Insurance Program. The policy contains all of the provisions, exclusions and qualifications of the insurance benefits. If any discrepancy exists between this summary and the policy, the policy will govern and control the payment of benefits.

ELIGIBILITY CRITERIA

For student-athletes to be eligible for coverage under the policy, injuries must meet the below criteria:

- Injuries must be sustained during participation in a qualifying intercollegiate sport (including NCAA emerging sports) on or after Aug. 1, 2024.
  - The policy DOES NOT cover injuries sustained while participating in club or intramural sports.
- Injuries must be reported and documented and filed with the athletics department of the school at which the student-athlete participated when the injury occurred.

BENEFIT PERIOD: TWO YEARS (104 WEEKS) AFTER SEPARATION FROM SCHOOL OR ATHLETICS

The consecutive two-year (104-week) benefit period begins as described below.

- Undergraduate: The benefit period begins on the earlier of the following for a student-athlete injured while an undergraduate student:
  - The date the student-athlete is no longer enrolled in school, except in the instance that the student-athlete's athletics season extends beyond enrollment, in which case the benefit period begins when the athletic season ends.
  - The date the student-athlete elects to voluntarily withdraw.
- Graduate: The benefit period begins on the earliest of the following for a student-athlete injured while a graduate student:
  - The date the student-athlete is no longer enrolled in school, except in the instance that the student-athlete's athletics season extends beyond enrollment, in which case the benefit period begins when the athletics season ends.
  - The date the student-athlete's athletics eligibility expires.
  - The date the student-athlete elects to voluntarily withdraw.
- Prospective Students: For a student-athlete injured while a prospective student, the benefit period begins on the date that the student-athlete is no longer enrolled as an undergraduate student.

The insurance industry standard for accidental injury coverage is for benefits to begin at the time of injury. The NCAA has developed a unique policy that applies when the student-athlete separates from school or voluntarily withdraws from athletics when other insurance coverage is not in place. Given the unique nature of the policy, uncertainty of losses and extended benefit period (upon separation from school or action to voluntarily withdraw as opposed to upon injury), 104 weeks was chosen to be the benefit period in line with the standard excess accidental injury policy benefit period and the benefit period that many member institutions choose when purchasing their excess accident student-athlete insurance coverage.

This is a general summary of the NCAA Post-Eligibility Insurance Program. The policy contains all of the provisions, exclusions and qualifications of the insurance benefits. If any discrepancy exists between this summary and the policy, the policy will govern and control the payment of benefits.

MEMBER SCHOOL RESPONSIBILITY

Member schools are responsible for establishing record-keeping procedures to document all intercollegiate athletics injuries. They also are responsible for retaining documentation of injuries until the benefit period of two years (104 weeks) is exhausted plus an additional year, while considering the following:

- If a student-athlete is injured as an undergraduate and transfers to another school (NCAA or another association), the benefit period begins when the undergraduate student-athlete is no longer enrolled in any school or voluntarily withdraws, whichever comes first.
    - For a student-athlete injured as a graduate student, the benefit period begins when the athlete exhausts athletics eligibility, voluntarily withdraws, or is no longer enrolled in any graduate program, whichever comes first.
    - For a student-athlete injured as a prospective student, the benefit period begins on the date that the student-athlete is no longer enrolled as an undergraduate student.

Voluntarily withdraws means submission of a formal voluntary withdrawal form from the student-athlete with no intent to transfer to and resume intercollegiate sport/activities at another school.

RELATIONSHIP TO PRIMARY INSURANCE

All student-athletes are required to have primary insurance that covers intercollegiate athletics injuries (either through private insurance or via the member institution's intercollegiate athletics injury policy or self-insurance program) up to $90,000. Many NCAA institutions choose to purchase a basic accident insurance policy to meet the NCAA's primary insurance requirement. Typically, the benefit period for basic accident insurance begins on the date of injury whereas the benefit period for post-eligibility insurance begins at the time of separation from school or voluntary withdrawal from athletics. Depending on the length of the benefit period for an institution's basic accident insurance, the post-eligibility insurance benefit period may extend the length of time in which a student-athlete may receive insurance coverage for eligible athletics injuries.

Post-eligibility insurance does not replace the requirement for DI member institutions and Division II and III programs that sponsor a Division I sport to provide medical care to student-athletes for athletically related injuries for two years after graduation or separation from the institution. The bylaw can be found here. Institutions have discretion to determine how medical care will be provided. There is no obligation for institutions to purchase additional insurance to cover the two-year period.

This is a general summary of the NCAA Post-Eligibility Insurance Program. The policy contains all of the provisions, exclusions and qualifications of the insurance benefits. If any discrepancy exists between this summary and the policy, the policy will govern and control the payment of benefits.

POST-ELIGIBILITY INSURANCE DETAILS

Carrier and Claims Adjuster

Mutual of Omaha Insurance Co. serves as the fronting carrier and claims adjuster for the post-eligibility insurance policy. Mutual of Omaha also coordinates the benefits of other insurance policies with the post-eligibility program, if applicable as part of the claims process.

How Claims Are Reported

Claims are reported to and managed by Mutual of Omaha Insurance Co. Information regarding the claim process can be found at www.posteligibilityinsurance.com.

Program Administrator

American Specialty Insurance & Risk Services serves as the program's administrator.

Financials

The policy's annual premium is $26 million, which is paid for by the NCAA. The annual premium payment is not expected to impact currently approved Association revenue distributions.

The policy has a $90,000 excess limit per injury, with no deductible. Of the $90,000 available, up to $25,000 is available for mental health services related to an injury.

Revised 7/12/2024

This is a general summary of the NCAA Post-Eligibility Insurance Program. The policy contains all of the provisions, exclusions and qualifications of the insurance benefits. If any discrepancy exists between this summary and the policy, the policy will govern and control the payment of benefits.

NCAA POST-ELIGIBILITY INSURANCE INFORMATION FOR STUDENT-ATHLETES AND FAMILIES

The NCAA sponsors a post-eligibility insurance program that begins Aug. 1, 2024, to support student-athletes beyond their playing days. **For up to two years after student-athletes separate from school** or voluntarily withdraw* from athletics, the program covers excess accident **medical expenses incurred after separation for athletically related injuries** sustained during participation in an NCAA qualifying intercollegiate sport. The program provides excess insurance coverage for properly documented covered injuries that occur on or after Aug. 1, 2024. The program is available to all student-athletes at all institutions in all divisions.

The coverage provides benefits in excess of any other valid and collectible insurance. The policy has a $90,000 excess limit per injury, with no deductible. Of the $90,000 available, up to $25,000 is available for mental health services related to an eligible, documented athletic injury.

No action by a student-athlete is needed to enroll in the program. Provided all coverage criteria are met within the benefit period, the policy is triggered when a student-athlete's primary insurance coverage is exhausted or when primary insurance will not cover accident medical expenses covered under the post-eligibility program, subject to terms and conditions of the policy.

Your benefit period begins on the date you separate from school or voluntarily withdraw* from athletics, whichever comes first.

What are my responsibilities prior to and during participation in college athletics?

- **Be sure to report all NCAA athletic injuries promptly** to your school's athletic department. Benefits from post-eligibility insurance will be contingent upon confirmation and documentation of the injury by a representative of the school's athletic department.
- Be aware of the medical care and insurance available to you, such as:
    - Medical care provided by your school for injuries.
    - Your personal health insurance, through a parent, guardian, employer, insurance marketplace, or health care sharing ministry arrangement.
    - Basic Accident Injury Insurance that may be available through your school.
    - NCAA Post-Eligibility Insurance.
    - NCAA Catastrophic Injury Insurance.
- Be aware that if you transfer schools, the school you attended at the time of the injury will need to confirm the details of your injury for a post-eligibility insurance claim.
- Notify your school if there are any changes to your personal health insurance.

What expenses are eligible for a claim?

- Treatment received during your benefit period for a covered injury may be eligible for reimbursement if out of pocket expenses remain after your primary insurance(s) or alternative

coverage has responded. The Incident Report Form should be fully completed and submitted with any relevant supporting documents to begin the claim process. This can occur at the start of the benefit period if you anticipate treatment or as treatment is being administered.
- Please refer to Description of Covered Expenses for a full list of eligible medical and mental health expenses.

What if I have a claim?

- Determine if you are eligible to file a claim by reviewing when the benefit period begins by utilizing our benefit period decision tree.
- Learn about the claim process and download an incident report form at www.posteligibilityinsurance.com.
- Understand that any accident medical expenses incurred during the benefit period related to an eligible intercollegiate athletics injury which occurred on or after Aug. 1, 2024, may be eligible for coverage up to the policy limit of $90,000.
- If your benefit period has begun, complete the injured student sections of the Incident Report Form and work with the athletic department at the school you attended at the time of the injury to complete the school section. Begin a claim by submitting the completed form to Mutual of Omaha by email, fax, or mail.
- Notify your healthcare provider(s) of excess insurance coverage that may be provided through Mutual of Omaha so the provider(s) may prepare itemized bills.

What is my school's role?

- Document athletic injuries in a timely manner. However, you as the student-athlete must make sure your athletic department is aware of your injury.
- Retain injury documentation for the duration of the benefit period plus one year.
- Collaborate to file a post-eligibility insurance claim by completing the sections of the Incident Report Form assigned to the authorized school representative.

*For the purposes of this policy, "voluntarily withdraw" means submission of a formal voluntary withdrawal form from the student-athlete with no intent to transfer to and resume intercollegiate sport/activities at another school.

NCAA's New Post-Eligibility Excess Insurance Program Will Cover Athletes in Any Division for Up to Two Years After Separation from Institution

Saxe Doernberger & Vita, P.C.

USA | June 26 2024

Effective August 1, 2024, the NCAA will provide excess injury insurance coverage to student-athletes for athletic injuries for two years, beginning on a student-athlete's date of separation from its member institution. The policy, with a coverage limit of $90,000 per injury and no deductible burden on the athlete, will be issued through Mutual of Omaha Insurance and will sit excess to other available insurance coverage. Notably, this coverage applies to all student-athletes, regardless of division, and is said to include some coverage for mental health care related to documented injuries.

NCAA bylaws impose a responsibility on member schools to ensure student-athletes are insured for athletic-related injuries with coverage referred to as "basic accident coverage." While member institutions can cover the cost of that coverage, the NCAA does not require they do so.[1] Those "basic" policies must have limits up to the deductible of the NCAA Catastrophic Injury Insurance Program ($90,000). The NCAA Catastrophic Injury Insurance Program offers medical and disability coverage to all student-athletes, coaches, and managers in excess of any other valid and collectible insurance – such as basic accident coverage – for injuries sustained during the policy period. Such underlying coverage includes medical, dental, rehabilitation and custodial care expense benefits, and disability benefits (total and partial, subject to numerous limitations), among others.

This new excess coverage extends accident medical coverage to student-athletes for properly documented injuries that occurred while playing for the member institution. The two-year (104-week) period begins after "separation" from the institution, which can be satisfied in several ways – for instance, when a student-athlete is no longer enrolled in a member institution or when a graduate student-athlete exhausts eligibility. Notably, the coverage period does not begin at the date of injury, as is typical for accidental injury coverage in the insurance world. This significantly extends available insurance resources for student-athletes, stretching coverage beyond eligibility and recognizing the long-term care some injuries require.

While NCAA athletes are already required to have medical insurance coverage, member institutions are not required to cover that expense for student-athletes. This new coverage does not impose any funding obligations on schools.

Because the NCAA's new excess insurance program is excess to all NCAA, institution, and student-athlete-procured insurance policies, it will not trigger until those policies are exhausted. However, this new program also has a different trigger date. An athlete's primary policies could exhaust before he/she separates from the school, but the NCAA Post-Eligibility coverage will not trigger until that separation, which could still leave student-athletes with a gap in coverage for athletic-related injuries.

While this post-eligibility insurance program is a good start, the information released by the NCAA does not specify the injuries that trigger this coverage, except that they must be "athletically related injuries."[2] Whether this means "during active participation" or simply "while a documented student-athlete" remains unclear, such that determining the scope of this coverage is somewhat unclear. There is also little insight on how to trigger the insuring agreement – that is, is it solely a student's separation from his or her institution with an athletically related injury that triggers coverage? Alternatively, is aggravation of an athletically related injury sufficient to trigger coverage during the two-year period following separation from an institution?

Saxe Doernberger & Vita, P.C. - Rachel S. Pearson

NCAA.org

Post-Eligibility Insurance Program

Post-Eligibility Insurance Program

Enrollment | Eligibility | Criteria | Benefit Period | Member School Responsibility | Insurance Details

The NCAA sponsors a post-eligibility insurance program that supports student-athletes beyond their playing days. For up to two years (104 weeks) after student-athletes separate from school or voluntarily withdraw from athletics, the program covers excess accident medical expenses for athletically related injuries sustained during participation in an NCAA qualifying intercollegiate sport. The program provides excess insurance coverage for properly documented covered injuries that occur on or after Aug. 1, 2024. The program is available to all student-athletes at all institutions in all divisions.

TWO-YEAR COVERAGE

The coverage provides benefits in excess of any other valid and collectible insurance. The policy has a $90,000 excess limit per injury, with no deductible. Of the $90,000 available, up to $25,000 is available for mental health services related to an eligible, documented athletic injury. For up to two years (104 weeks) after student-athletes separate from school or voluntarily withdraw from

athletics, the program covers excess accident medical expenses for athletically related injuries sustained during participation in an NCAA qualifying intercollegiate sport.

AUTOMATIC ENROLLMENT

No action by a student-athlete is needed to enroll in the program. Provided all coverage criteria are met within the benefit period, the policy will be triggered when a student-athlete's primary insurance coverage is exhausted or when primary insurance will not cover accident medical expenses covered under the post-eligibility program, subject to terms and conditions of the policy.

ALL THREE DIVISIONS

The program is available to all student-athletes at all institutions in all divisions. For Division I members and Division II or Division III programs that sponsor a Division I sport: This does not replace the requirement for schools to provide medical care to student-athletes and reimburse out-of-pocket expenses related to athletic injuries for two years after separation from school. Institutions have discretion to determine how medical care will be provided. There is no obligation for institutions to purchase additional insurance to cover the two-year period.

ENROLLMENT

Student-athletes are automatically covered under the policy for those qualifying intercollegiate athletics injuries that meet both of the following conditions:

- Occur during the policy period (on or after Aug. 1, 2024).
- Are documented and on file with the institution's athletics department.

Student-athletes DO NOT need to opt in for coverage before an injury occurs. Those who transfer, are part- or full-time students, or are later deemed ineligible for NCAA competition would be covered under the policy, provided the eligibility criteria is met. International student-athletes also are covered under the program subject to the regulations of the athlete's country of origin. Action is not required by the student-athlete unless the student-athlete needs to file a claim during the benefit period.

ELIGIBILITY CRITERIA

For student-athletes to be eligible for coverage under the policy, injuries must meet the below criteria:

- Injuries must be sustained during participation in a qualifying intercollegiate sport (including NCAA emerging sports) on or after Aug. 1, 2024.
    - The policy DOES NOT cover injuries sustained while participating in club or intramural sports.

- Injuries must be reported and documented and filed with the athletics department of the school at which the student-athlete participated when the injury occurred.

BENEFIT PERIOD

The consecutive two-year (104-week) benefit period begins as described below:

- **Undergraduate** - The benefit period begins on the earlier of the following for a student-athlete injured while an undergraduate student:
  - The date the student-athlete is no longer enrolled in school, except in the instance that the student-athlete's athletics season extends beyond enrollment, in which case the benefit period begins when the athletic season ends.
  - The date the student-athlete elects to voluntarily withdraw.
- **Graduate** - The benefit period begins on the earliest of the following for a student-athlete injured while a graduate student:
  - The date the student-athlete is no longer enrolled in school, except in the instance that the student-athlete's athletics season extends beyond enrollment, in which case the benefit period begins when the athletics season ends.
  - The date the student-athlete's athletics eligibility expires.
  - The date the student-athlete elects to voluntarily withdraw.
- **Prospective Students** - For a student-athlete injured while a prospective student, the benefit period begins on the date that the student-athlete is no longer enrolled as an undergraduate student.

The insurance industry standard for accidental injury coverage is for benefits to begin at the time of injury. The NCAA has developed a unique policy that applies when the student-athlete separates from school or voluntarily withdraws from athletics when other insurance coverage is not in place. Given the unique nature of the policy, uncertainty of losses and extended benefit period (upon separation from school or action to voluntarily withdraw as opposed to upon injury), 104 weeks was chosen to be the benefit period in line with the standard excess accidental injury policy benefit period and the benefit period that many member institutions choose when purchasing their excess accident student-athlete insurance coverage.

MEMBER SCHOOL RESPONSIBILITY

Member schools are responsible for establishing record-keeping procedures to document all intercollegiate athletics injuries. They also are responsible for retaining documentation of injuries until the benefit period of two years (104 weeks) is exhausted plus an additional year, while considering the following:

- If a student-athlete is injured as an undergraduate and transfers to another school (NCAA or another association), the benefit period begins when the undergraduate student-athlete is no longer enrolled in any school or voluntarily withdraws, whichever comes first.
  - For a student-athlete injured as a graduate student, the benefit period begins when the athlete exhausts athletics eligibility, voluntarily withdraws, or is no longer enrolled in any graduate program, whichever comes first.
  - For a student-athlete injured as a prospective student, the benefit period begins on the date that the student-athlete is no longer enrolled as an undergraduate student.

Voluntarily withdraws means submission of a formal voluntary withdrawal form from the student-athlete with no intent to transfer to and resume intercollegiate sport/activities at another school.

INSURANCE DETAILS

All student-athletes are required to have primary insurance that covers intercollegiate athletics injuries (either through private insurance or via the member institution's intercollegiate athletics injury policy or self-insurance program) up to $90,000. Many NCAA institutions choose to purchase a basic accident insurance policy to meet the NCAA's primary insurance requirement. Typically, the benefit period for basic accident insurance begins on the date of injury whereas the benefit period for post-eligibility insurance begins at the time of separation from school or voluntary withdrawal from athletics. Depending on the length of the benefit period for an institution's basic accident insurance, the post-eligibility insurance benefit period may extend the length of time in which a student-athlete may receive insurance coverage for eligible athletics injuries.

Post-eligibility insurance does not replace the requirement for DI member institutions and Division II and III programs that sponsor a Division I sport to provide medical care to student-athletes for athletically related injuries for two years after graduation or separation from the institution. The bylaw can be found here. Institutions have discretion to determine how medical care will be provided. There is no obligation for institutions to purchase additional insurance to cover the two-year period.

Carrier and Claims Adjuster

Mutual of Omaha Insurance Co. serves as the fronting carrier and A-G Specialty Insurance serves as the claims adjuster for the post eligibility insurance policy.

A-G Specialty Insurance and Mutual of Omaha also coordinate the benefits of other insurance policies with the post-eligibility program, if applicable as part of the claims process.

How Claims Are Reported

Claims are reported to and managed by A-G Specialty Insurance. Information regarding the claim process can be found at www.posteligibilityinsurance.com.

Program Administrator

American Specialty Insurance & Risk Services serves as the program's administrator.

Financials

The policy's annual premium is $26 million, which is paid for by the NCAA. The annual premium payment is not expected to impact currently approved Association revenue distributions.

The policy has a $90,000 excess limit per injury, with no deductible. Of the $90,000 available, up to $25,000 is available for mental health services related to an injury.

This is a general summary of the NCAA Post-Eligibility Insurance Program. The policy contains all of the provisions, exclusions and qualifications of the insurance benefits. If any discrepancy exists between this summary and the policy, the policy will govern and control the payment of benefits.

Resources

- Frequently Asked Questions
- File a Claim
- Contact Us
- PEI Townhall Recording

NCAA Post-Eligibility Insurance Incident Report Form

Directions

Use this checklist for the PEI incident report form to ensure each section is completed by the correct party.

INJURED STUDENT-ATHLETE

- ☐ Complete Part I
- ☐ Complete Part II
- ☐ Complete Part III
- ☐ Sign Part V

AUTHORIZED SCHOOL REPRESENTATIVE

- ☐ Review Part II and Sign
- ☐ Complete Part IV
- ☐ Sign Part V

After completion, please send the form to:

MUTUAL OF OMAHA

PO Box 31156
Omaha, NE 68131
Fax: (402) 351-4732
1-800-524-2324
specialrisk.pei@mutualofomaha.com

Part I: Injured Student Information

Injured Student's Full Name:

Did the injury occur on or after 8/1/2024:
☐ Yes ☐ No
If no, you are not eligible for coverage. Please contact Nikki Hammond at nhammond@americanspecialty.com for additional information.

Date of Birth:

E-mail:

Mailing Address of Injured Student:

Alternate E-mail:

Contact Phone Number of Injured Student:

If Applicable, Parent or Guardian Name, Address, and Best Contact Phone Number (Include Area Code):

Part I Continued: Injured Student Information

Date of Injury:

Type of Injury:

Body Part Injured:

Side Affected: ☐ Left ☐ Right

Injury Occurred During:

- ☐ Qualifying Intercollegiate Sport Competition
- ☐ Official Team Activities
- ☐ Supervised Conditioning
- ☐ Practice Session
- ☐ Covered Travel (authorized and paid for by the school)
- ☐ Other Covered Event

Injury occurred during the ☐ Beginning ☐ Middle **or** ☐ End **of this activity.**

If other, please explain:

Sport: ☐ Acrobatics/Tumbling ☐ Baseball ☐ Basketball ☐ Beach Volleyball ☐ Bowling ☐ Cross Country ☐ Equestrian ☐ Fencing ☐ Field Hockey ☐ Football ☐ Golf ☐ Gymnastics ☐ Ice Hockey ☐ Lacrosse ☐ Rifle ☐ Rowing ☐ Rugby ☐ Skiing ☐ Soccer ☐ Softball ☐ Stunt ☐ Swimming/Diving ☐ Tennis ☐ Track (Indoor) ☐ Track (Outdoor) ☐ Triathlon ☐ Volleyball ☐ Water Polo ☐ Wrestling ☐ Other Qualifying Intercollegiate Sport

Type: ☐ Men's ☐ Women's ☐ Coed

If other, describe:

Describe how injury occurred:

Injured Student's Involvement in Sport at Time of Injury:

☐ Athlete ☐ Cheerleader ☐ Mascot ☐ Enrolled Prospective Student ☐ Trainer ☐ Coach ☐ Manager

Did you receive mental health support as a result of this injury: ☐ Yes ☐ No

Part II: Collegiate Status

Athletic year on date of injury: ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ 5th Year Senior

☐ Other Undergraduate Student ☐ Graduate Student ☐ Enrolled Prospective Student

If Graduate Student, please provide your NCAA Athletic Eligibility Expiration Date:

Have you been continuously enrolled in school since your injury? ☐ Yes ☐ No

If YES:

Post-eligibility insurance is available to enrolled students who have submitted a formal voluntary withdrawal form. This indicates you have withdrawn from your qualifying intercollegiate sport with no intent to transfer to and resume intercollegiate sport/activities at any active or provisional NCAA member school.

Do you have a Voluntary Withdrawal form on file at your institution? ☐ Yes ☐ No

If Yes, date of Voluntary Withdrawal:

If NO:

What is the first date that you separated from school?

Note: Provide your graduation date if you graduated without being enrolled in future classes. If you separated from school without graduating and were not enrolled in future classes, provide the last date you were enrolled in classes (prior to discontinuing enrollment). Regularly scheduled school breaks are not considered a gap in enrollment.

What is the reason you separated from school on that date?

☐ Graduation ☐ My Injury

☐ Illness of Myself or a Family Member ☐ Financial

☐ Academic Ineligibility

☐ Intended to Transfer but Did Not Re-enroll ☐ Other

Did your NCAA athletic season (immediately prior to your first separation from school) extend beyond your enrollment in school? ☐ Yes ☐ No

If Yes, on what date did that NCAA athletic season end?

I give permission for my institution to provide my student health records to Mutual of Omaha for the purpose of verifying this post-eligibility insurance claim.

Injured Student Signature: **Date:**

Authorized School Representative sign here to confirm accuracy of information in PART II — Collegiate Status

Signature: **Date:**

Part III: Other Insurance Statement

Are you covered as an individual, employee, or dependent member of a spouse or parent on any of the following coverages: a) an individual or group policy of health insurance or accident insurance; or b) a health care sharing ministry or similar health care sharing arrangement; or c) any prepaid service arrangement such as a Health Maintenance Organization (HMO); d) or eligible to receive benefits from Medicare? If so, please list all such policies or coverages other than Medicaid or Tricare. ☐ Yes ☐ No

If yes, name of insurance company or coverage organization:

Policy #:

If applicable, name of additional insurance company or coverage organization:

Policy #:

Part IV: Member Institution

Name of School:

Authorized Representative of School:

School Address:

Job Title:

Phone:

Date of Initial Report of Injury:

Email:

Division: ☐ FBS ☐ FCS ☐ Division I - No Football ☐ Division II - Football ☐ Division II - No Football ☐ Division III - Football ☐ Division III - No Football

Does the school have documentation on file of the injury? ☐ Yes ☐ No

If no, the injured student is not eligible for coverage. Please contact Nikki Hammond at nhammond@americanspecialty.com for additional information.

Did the injury occur during a qualifying intercollegiate sport competition, official team activities, supervised conditioning, practice session, or covered travel (authorized and paid for by the school)? ☐ Yes ☐ No

Does the school have a basic accident policy or self-insurance policy that currently provides benefits to this student for the injury that is reported on this form (i.e., the injury date is within the benefit period and the policy maximum has not been paid)? ☐ Yes ☐ No

Applicable Plan Details:

Part V: Authorization to Pay Benefits to Provider

I authorize medical payments to a physician or supplier for services described on any attached statements enclosed. I further authorize that all the information in this form is true, correct and complete to the best of my knowledge.

Injured Student Signature: **Date:**

I authorize that all of the information in this form is true, correct and complete to the best of my knowledge.

Authorized School Representative Signature: **Date:**

NCAA POST-ELIGIBILITY INSURANCE: DESCRIPTION OF COVERED EXPENSES

Mutual of Omaha will pay the following medical expenses and mental health expenses incurred during the benefit period as a result of a covered injury sustained during participation in a qualifying intercollegiate sport.
All benefits are subject to the benefit percentages and other provisions of the policy. The maximum benefit amount is $90,000 and the sub-limit amount for mental health expenses related to the covered injury is $25,000.

MEDICAL BENEFITS

1. Hospital room and board charges, up to the average semi-private daily room rate, for each day in the hospital;
2. Intensive care unit charges are payable in lieu of payment for hospital room and board charges for each day the insured person is confined in an intensive care unit;
3. Hospital miscellaneous charges during a hospital confinement. Miscellaneous charges do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take-home items, or other convenience items;
4. Outpatient charges by a hospital or outpatient surgical center for:
    - emergency room treatment;
    - emergency room physician; or
    - use of surgical facilities;
5. Surgical charges for the primary performance of a surgical procedure by a physician subject to the following:
    - if bilateral or multiple surgical procedures are performed by one physician, Mutual of Omaha will pay the medical expenses for the primary procedure;
    - for each procedure that is not the primary procedure performed through the same incision as the primary procedure, Mutual of Omaha will pay 50% of the amount otherwise payable if the additional procedure were the primary procedure;
    - if multiple surgical procedures are performed during the same operating session, reimbursement shall be based upon 100% of allowable expense for the primary procedure, 50% of allowable expense for the secondary procedure and 25% of allowable expense for the third and subsequent procedures;
    - any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered incidental and no benefits will be provided for such procedure;
    - if multiple unrelated surgical procedures are performed by two or more physicians on separate operative fields, benefits will be based on the medical expenses for each physician's primary procedure; and
    - if two or more physicians perform a procedure that is normally performed by one physician, Mutual of Omaha will only pay the medical expenses for the primary physician;
6. Charges for a second surgical opinion or consultation by a physician;
7. Surgical charges for assistant surgeon duties will be reimbursed at 25% of the allowable for surgery codes that have been assigned an assistant surgery indicator by the Centers for Medicare & Medicaid Services;
8. Charges for anesthesia and its administration for surgery;
9. Physician's charges for other than pre- or post-operative care for in-hospital visits or office visits;
10. Charges for, including physician's charges for reading or interpreting the results of, laboratory tests and diagnostic imaging including X-Ray, MRI, or CAT Scan;
11. Charges for nursing services, other than routine hospital care, by or under the supervision of a nurse;
12. Treatment of the spine by manual or mechanical means;
13. Charges for durable medical equipment;
14. Charges for physiotherapy which includes:
    - adjustment;
    - diathermy;
    - heat treatment;

This is a general summary of the NCAA Post-Eligibility Insurance Program. The policy contains all of the provisions, exclusions and qualifications of the insurance benefits. If any discrepancy exists between this summary and the policy, the policy will govern and control the payment of benefits.

- manipulation;
- microtherm;
- ultrasonic;

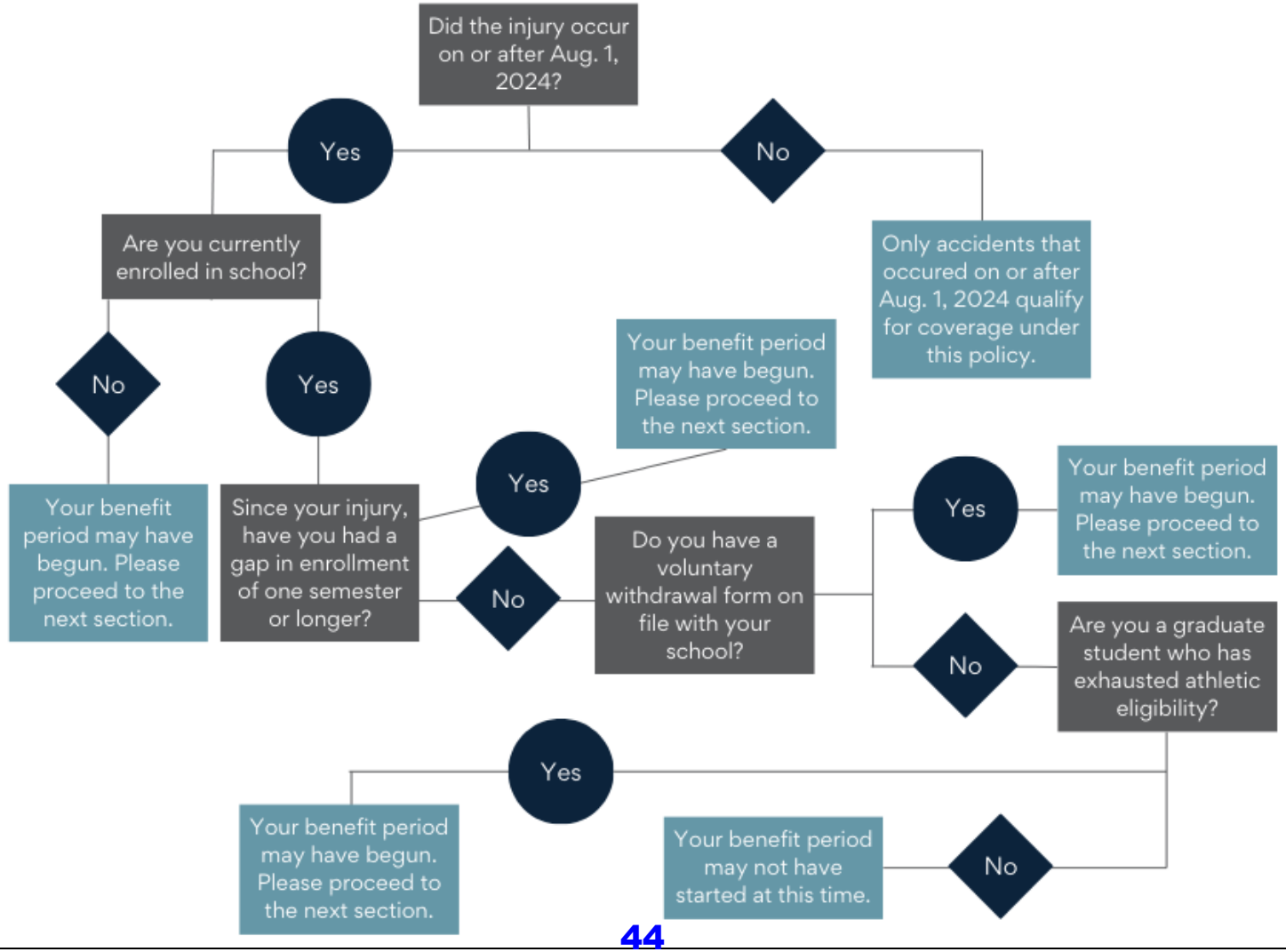
15. Ambulance service (surface) or/and ambulance service (air);
16. Orthopedic appliances and prosthetics, not including replacements;
17. Prescription drugs; and
18. Dental expense for sound natural teeth, implants, or dentures that were in place at the time of the NCAA recognized injury;
19. Eyeglasses, contact lenses, hearing aids, or related examinations or prescriptions.

MENTAL HEALTH BENEFITS

1. Hospital room and board charges, up to the average semi-private daily room rate, for each day in the hospital;
2. Intensive care unit charges are payable in lieu of payment for hospital room and board charges for each day the insured person is confined in an intensive care unit;
3. Hospital miscellaneous charges during a hospital confinement. Miscellaneous charges do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take-home items, or other convenience items;
4. Outpatient charges by a hospital for:
    - emergency room treatment; or
    - emergency room physician;
5. Physician's or mental health practitioner's charges for in-hospital visits or office visits;
6. Charges for, including physician's or mental health practitioner's charges for reading or interpreting the results of, laboratory tests;
7. Charges for nursing services, other than routine hospital care, by or under the supervision of a nurse;
8. Ambulance service (surface);
9. Prescription drugs;
10. Outpatient treatment received while not confined as an inpatient in a hospital, psychiatric hospital, or residential treatment facility, including:
    - Individual, group, and family therapies for the treatment of mental and nervous disorders;
    - Other outpatient mental health treatment such as:
        - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician or mental health practitioner;
        - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician or mental health practitioner;
        - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
            - The insured person is homebound;
            - The insured person's physician orders them;
            - The services take the place of a stay in a hospital or a residential treatment facility, or the insured person is unable to receive the same services outside the insured person's home;
            - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease;
        - Electro-convulsive therapy (ECT);
        - Transcranial magnetic stimulation (TMS);
        - Psychological testing;
        - Neuropsychological testing;
        - Peer counseling support by a peer support specialist (including telemedicine consultation).

NCAA POST-ELIGIBILITY INSURANCE: DETERMINE IF YOU ARE READY TO FILE A CLAIM

Medical expenses that are incurred during the benefit period for covered injuries may be reimbursed by filing a claim. A covered injury is one which occurs during participation in an NCAA qualifying intercollegiate sport. Your benefit period begins on the date you separate from school or formally voluntarily withdraw* from athletics, whichever comes first. Before submitting a claim, determine if your benefit period has begun by using the decision tree below.



1. If you believe your benefit period has begun, the **Incident Report Form** should be fully completed and submitted with any relevant supporting documents to begin the claim process. This can occur at the start of the benefit period if you anticipate treatment or as treatment is being administered.
2. Expenses incurred before or after your benefit period are not eligible for coverage under this policy at this time.
3. Items you will need to complete the Incident Report Form:
    - Other insurance information (Name of Insurance Company and Policy Number).
    - Contact information for the athletic department of the school you attended at the time of the injury.
    - Dates of:
        - Injury
        - Initial treatment
        - Last day enrolled in school (if not longer enrolled)
        - Expiration of athletic eligibility (graduate students)
    - If applicable, a copy of your voluntary withdrawal form.

*For the purposes of this policy, “voluntarily withdraw” means submission of a formal voluntary withdrawal form from the student-athlete with no intent to transfer to and resume intercollegiate sport/activities at another school.

NCAA POST-ELIGIBILITY INSURANCE INFORMATION FOR ATHLETICS DEPARTMENTS

The NCAA sponsors a post-eligibility insurance program that begins Aug. 1, 2024, to support student-athletes beyond their playing days. **For up to two years after student-athletes separate from school** or voluntarily withdraw* from athletics, the program covers excess accident **medical expenses for athletically related injuries** sustained during participation in an NCAA qualifying intercollegiate sport. The program provides excess insurance coverage for properly **documented covered injuries that occur on or after Aug. 1, 2024**. The program is available to all student-athletes at all institutions in all divisions.

The coverage provides benefits in excess of any other valid and collectible insurance. The policy has a $90,000 excess limit per injury, with no deductible. Of the $90,000 available, up to $25,000 is available for mental health services related to an eligible, documented athletic injury.

No action by a student-athlete is needed to enroll in the program. Provided all coverage criteria are met within the benefit period, the policy is triggered when a student-athlete's primary insurance coverage is exhausted or when primary insurance will not cover accident medical expenses covered under the post-eligibility program, subject to terms and conditions of the policy.

For Division I members and Division II or Division III members that sponsor a Division I sport: This does not replace the holistic model requirement for member institutions to provide medical care to student-athletes and reimburse out-of-pocket expenses related to athletic injuries for two years after separation from school. Institutions have no obligation to purchase additional insurance to cover the two-year period.

To learn more about the NCAA's Post-Eligibility Insurance program, please visit www.ncaa.org/sports/2023/8/17/ncaa-post-eligibility-insurance-program.aspx.

What are my institution's responsibilities?

- **Document all athletic injuries**. Injury documentation is required for a post-eligibility insurance claim.
- Review your state laws and refer to best practices for medical documentation from recognized athletic training organizations.
- Assess your current injury tracking processes to ensure injuries are being documented consistently and in a timely manner.
- Remember that mental health services which are related to a documented intercollegiate athletic injury may be eligible for coverage and therefore need to be documented internally as such.
- Be aware of the insurance available to student-athletes, including but not limited to:
    - Their personal health insurance, through a parent, guardian, employer, insurance marketplace, or health care sharing ministry arrangement.

    - Basic Accident Injury Insurance, if available through your institution.
    - NCAA Post-Eligibility Insurance.
    - NCAA Catastrophic Injury Insurance.

- Ensure that athletic injury records are retained for the duration of the 104-week benefit period plus an additional year. This is to ensure that athletic injury records remain on file in case a claim is submitted after conclusion of the benefit period for service previously provided during the benefit period. The benefit period begins the earlier of the date the student-athlete is no longer enrolled in school or elects to voluntarily withdraw (or in the case of a student-athlete injured as a graduate student, exhausts athletics eligibility). It is possible that a student may transfer from the initial member institution but may still be continuously enrolled for a number of years before their benefit period begins.
- Collaborate with former student-athletes to file their post-eligibility insurance claim by completing the sections assigned to the authorized representative of the member institution.
- Review your institution's voluntary withdrawal form, if applicable. The benefit period begins at the time a student-athlete is no longer enrolled in school or submits a voluntary withdrawal form to formally withdraw from intercollegiate athletics with no intention of resuming participation in intercollegiate athletics at any institution.
- Review exit interview processes so exiting student-athletes receive information about post-eligibility insurance.
- Encourage post-eligibility insurance education with student-athletes and staff.

What is my institution's role in the event of a claim?

- A claim can be initiated by the member institution or the student-athlete, but the claims process requires input from both the student-athlete and an authorized institution representative. Learn more or begin the claim process at www.posteligibilityinsurance.com.
- Designate an authorized representative to complete the member-institution section of the incident report form. This should be a current employee who has access to athletic injury records and can acknowledge via signature the following items:
    - Date and description of injury,
    - Date of initial report and description of initial treatment of injury,
    - Student-athlete name and sport,
    - Whether the injury occurred during competition, practice, conditioning, etc.,
    - Confirmation that the claim is on file with the member institution via the member institution's injury documentation protocols,
    - Confirmation of the student-athlete's last date of enrollment at the member institution,
    - Applicable institutional basic accident insurance policy or self-insurance policy information, if any.

*For the purposes of this policy, "voluntarily withdraw" means submission of a formal voluntary withdrawal form from the student-athlete with no intent to transfer to and resume intercollegiate sport/activities at another school.

This is a general summary of the NCAA Post-Eligibility Insurance Program. The policy contains all the provisions, exclusions, and qualifications of the insurance benefits. If any discrepancy exists between this summary and the policy, the policy will govern and control the payment of benefits.

Agenda Item A6
CSURMA AIME Committee
Meeting Date: January 21, 2025

CSURMA PLAN OF BENEFITS

ISSUE: The Committee reviewed and revised the CSURMA Plan of Benefits in January 2016. The Committee will receive a report and be asked to discuss the current CSURMA Plan of Benefits and the NCAA policy.

RECOMMENDATION: It is recommended that the Committee review and discuss the current Plan of Benefits.

FISCAL IMPACT: None

BACKGROUND: The CSURMA Plan of Benefits was last reviewed in the Fiscal Year 2016. The Committee discussed and agreed to review the CSURMA Plan of Benefits with the goal of applying values and language to coincide with the current medical industry and the NCAA catastrophic policy.

PUBLICATION: None

ATTACHMENT(S):

a. 2024-2025 CSURMA Plan of Benefits
b. NCAA Policy 08 01 23 – 07 31 24
c. Comparison Summary of Plan of Benefits vs. NCAA Policy (Handout)

ATHLETIC INJURY MEDICAL EXPENSE (AIME)
PLAN OF BENEFITS

DESIGNED FOR THE ATHLETES OF THE
CALIFORNIA STATE UNIVERSITY SYSTEM
2024-2025

Following is a plan of benefits that is self-funded by the participating campuses of the California State University System (hereinafter referred to as CSURMA/AIME) in excess of other valid and collectible insurance.

PART I - COVERED PERSONS

Any regularly enrolled student who is a participant on the intercollegiate team roster of the participating CSU campus, or is engaged in scheduled activities to become a roster participant of an intercollegiate team of the participating CSU campus. Coverage for student-athletes, student coaches, student managers, athletic training students and student cheerleaders who are injured while participating in a Covered Activity.

PART II - COVERED ACTIVITIES

Benefits are limited to injuries sustained during participation in regularly scheduled intercollegiate sports events of the participating CSU campus, including during the regular season for such sport and the supervised or *customary activities within the scope of such sport*. Coverage includes the sports listed on the sports census from each participating CSU campus.

Benefits for a Covered Event are for players on an athletic team who are qualifying intercollegiate sport competition scheduled by the CSU campus, official team activities; conditioning; and practice sessions.

For players on an athletic team, Covered Event must be authorized by, organized by or directly supervised by an official representative of the CSU campus (not including any activities not directly a part of a Qualifying Intercollegiate Sport, such as camps, clinics and other events not conducted by the CSU campus).

Covered Event, for Student Cheerleaders, does not include any activities, camps, clinics, national competitions, fund-raisers, alumni events; unless the activity is directly associated with the activities of a Qualifying Intercollegiate Sport team or conducted by the Insured Person's Participating School.

PART III – DEFINITIONS

"Expense" means those charges that would be made even in the absence of these benefits for treatment and service performed and supplies furnished which are usual, reasonable and customary charges as compared to charges for like treatment, service and supplies in the geographic area where treatment is performed.

"Extended care facility" means an institution operating pursuant to law which is engaged in providing, for a fee, skilled nursing care and related services and physical therapy services under the supervision of a doctor and graduate registered nurses, to persons convalescing from illness. It must have facilities for ten (10) or more inpatients and maintain clerical records on all of its patients. To qualify as a medical expense under this policy, the covered person's confinement in an extended care facility must:

a. start within five (5) days after the covered person has been continuously confined for at least five (5) days in a hospital as a result of a covered accident; and
b. be for treatment of the injuries resulting from such covered accident; and
c. be one during which a doctor visits the covered person at least once every thirty (30) days; and
d. be certified to be medically necessary by the attending doctor; and
e. not be for routine custodial care.

"Home health care" means nursing care and treatment of a covered person in his/her home as part of an overall extended treatment plan. To qualify, the plan must:

a. be established by and approved in writing by the attending doctor; and
b. be provided by a hospital certified to provide home health care services or by a certified home health care agency; and
c. commence within seven (7) days of discharge from a hospital or extended care facility; and
d. be preceded by a hospital or extended care facility confinement of five (5) days or more.

No benefits will be paid for home health care services which are general housekeeping services or custodial care services, or which are provided by a member of the covered person's immediate family or by an individual who resides with the covered person.

"Hospital" means an institution that meets all of the following requirements:

a. it is licensed (if required) as a hospital; and
b. it is open at all times; and
c. it is operated mainly to diagnose and treat illnesses on an inpatient basis; and
d. it has a staff of one (1) or more doctors on call at all times; and
e. it has twenty-four (24) hour nursing services by registered nurses; and
f. it is not mainly a skilled nursing facility, clinic, nursing home, rest home, convalescent home or like place; and
g. it has organized facilities for surgery or provides for such facilities for its patients through formal written agreement with other hospitals.

"Injury" means bodily injury caused by an accident occurring while these benefits are in force as to the insured whose injury is the basis of claim and which results directly and independently of all other causes in loss covered by these benefits.

"Intoxication" or "intoxicated" means that the level of alcohol in the blood of the covered person exceeds the level above which a person is presumed, in the locale in which the accident occurred, to be under the influence of alcohol or intoxicating liquor if operating a motor vehicle, regardless of whether the covered person is in fact operating a motor vehicle when the injury or loss occurs.

"Luxury Item" Treatments, devices or other healing-related items which represent new or unique methodologies of treatment that are not representative of prevailing procedures utilized for such injuries. Luxury items shall be limited to medical necessity only.

"Physician" means a person not related to the covered person licensed for the practice of medicine, osteopathy, dentistry, optometry, physical therapy, podiatry, or other legally licensed provider acting within the scope of his license. Specialists must be referred by the CSU campus team physician.

"Usual, reasonable and customary charge" means the normal charge, in absence of insurance, of the provider for the service or supply, but not more than the prevailing charge in the area for a like service or supply. A like service is of the same nature and duration, requires the same skill, and is performed by a provider of similar training and experience. A like supply is one that is identical or substantially equivalent. "Area" means the municipality (or in the case of a large city, the subdivision thereof) in which the service or supply is actually provided or such greater area as is necessary to obtain a representative cross-section of charges for a like service or supply.

PART IV – BENEFITS

A. Medical Expense

When a covered person requires medical services as the result of an injury covered under these benefits, the CSURMA/AIME will pay the expenses actually incurred for the necessary treatment of such injury. Expenses include:

1. Physician and surgeon fees
2. Dentist fees for injury to sound and natural teeth
3. Cost of confinement in a hospital or medically necessary extended care facility
4. Use of a hospital emergency room
5. Cost of home health care
6. Anesthetic (including administration thereof)
7. X-ray examinations or treatments
8. Laboratory tests
9. Prescription drugs, if prescribed by the covered person's physician
10. Physical therapy fees
11. Orthopedic appliances if prescribed by the covered person's physician (not chiropractor)
12. Chiropractic fees up to a maximum of 26 visits (from the date of first visit to the maximum of 26 visits per athlete/per injury)
13. *Payment as primary on the first $5,000 of diagnostic billings for covered accident or injury, when the student has an "Out-of-Network" coverage plan.*

The first expense must be incurred within 120 days of the date of accident and only expenses incurred within 104 consecutive weeks from the date of accident will be reimbursed hereunder, up to a maximum of *$90,000* (NCAA) or $25,000 (NAIA) as the result of one covered person's accident. *Claims must be submitted within 18 months of the date of service for follow up treatment.*

The amount of benefits available from the Plan shall be reduced by an amount equal to the greater of:

a) The amount payable under any other plan of insurance as determined under C. set forth below, or

b) The amount of $0.00 or such larger amount as is designated as a deductible applicable to the particular sport or sports by the participating institution as shown in the participation agreement.

B. Expanded Medical Benefits shall include the following:

1. A re-injury or aggravation of an injury sustained prior to participation in the participating CSU campus athletic program provided the covered person was provided medical clearance to

participate in the appropriate athletic activity by the CSU campus team physician, and such re-injury or aggravation occurs in a covered event;

2. The following list of conditions that are attributable to exertion from participating in a covered activity: tendonitis, bursitis, hernia, strains, sprains, shin splints, stress fractures and similar conditions.

3. Cardiovascular accident or similar traumatic event caused by exertion while participating in a covered activity. The CSURMA/AIME will provide benefits for the actual injury sustained and testing, but not the follow up care if the condition is found to be congenital in nature.

C. **Excess Provision**

The benefits described above shall be payable only on an excess basis over and above any benefits or services provided for by any of the plans listed below, regardless of any coordination of benefits, non-duplication of benefits or similar clause contained in such plans.

The word "plan" means any of the following that provides benefits for medical or dental care or treatment:

1. Group, blanket, or franchise health insurance coverage;

2. Any other arrangement of coverage for individuals in 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 accidental bodily injuries arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever name called, including such benefits mandated by law) of any automobile insurance policy;

5. Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefits organization plans;

6. Any plan or program solely or largely provided by or through any government action or law to the extent that benefits are payable under such plan or program.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be considered in determining the applicability of this provision. The benefits payable under a plan shall include the benefits that would have been payable had a claim been duly made.

The benefits payable shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits provided for by any other plan shall not exceed the total of the expenses incurred by the covered person.

D. **"Out-of-Network" Provision**

If a student athlete suffers a loss while this plan is in force and they have coverage with an HMO or PPO that would deny coverage for service outside its geographic area or its provider network, the CSURMA/AIME will cover for such expense if the CSU campus Athletic Director or designee has approved such expenses.

E. **Third Party Refund**

When a covered person is injured through the negligent act or omission of another person (the "third party") and benefits are paid under the Plan as a result of that Injury, the Risk Pool is entitled to a refund by the covered person of all Plan benefits paid as a result of the Injury. The refund must be made to the extent that the covered person receives payment for the Injury from the third party or that the third party's insurance carrier. We may file a lien against that third-party payment. Reasonable pro-rata charges, such as legal fees and court costs may be deducted from the refund made to the Risk Pool. The covered person must complete and return the required forms to the Risk Pool upon request.

PART V – EXCLUSIONS

No benefits are payable for:

1. Suicide or any attempt thereat by a covered person;
2. Intentionally self-inflicted injuries;
3. Infections, except pyogenic infections due to accidental cut;
4. Accident occurring while the covered person is operating, or learning to operate, or performing duties as a member of the crew of any aircraft;
5. Dental treatment, except as a result of injury to sound and natural teeth as provided for in these benefits;
6. Replacement of eyeglasses, or eye examinations of the correction of vision or fitting of glasses unless an injury has caused impairment of sight;
7. Injury for which the covered person is entitled to benefits under any Workers' Compensation Act or law or similar legislation;
8. The covered person being intoxicated, unless administered on the advice of a physician;
9. Any injury occurring other than as a participant in a CSU campus intercollegiate athletic event, or the practice thereof;
10. Expenses for the treatment of sickness or disease in any form.

PART VI - GENERAL PROVISIONS

A. No statement made by the covered person shall void the benefits thereunder unless continued in a written instrument signed by the covered person. All statements contained in any such written instrument shall be deemed representations and not warranties.

B. No staff has authority to change these benefits or waive any of its provisions. No change in these benefits shall be valid unless approved by the CSURMA Board of Directors and the AIME Committee and evidenced by amendment to these benefits.

C. Written notice of loss must be given to the CSURMA/AIME claims administrator within thirty (30) days after the date when such loss occurred. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice, and that notice was given as soon as was reasonably possible.

D. Written proof of loss must be furnished to the CSURMA/AIME claims administrator within ninety (90) days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.

E. All benefits are payable immediately after receipt of due proof.

F. The CSURMA/AIME shall have the right and opportunity to examine the covered person when and so often as it may be reasonably required during the pendency of claim. Such examination shall be at the CSURMA/AIME expense.

G. Benefits are payable to the covered person, except that the CSURMA/AIME, at their option, may make payment for hospital, surgical or medical service directly to the hospital or person or persons furnishing such service.

H. No action at law or in equity shall be brought to recover prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of these provisions and no such action shall be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by these provisions.

I. If any time limitations of these provisions with respect to giving notice of claim or furnishing proof of loss, or the bringing of an action at law or in equity is less than that permitted by California law, such limitation is hereby extended to agree with minimum period permitted by such law.

ADMINISTRATIVE RESPONSIBILITIES OF THE CSURMA/AIME

1. Complete on-line claim form.

2. Send primary insurance information to the claims administrator (HSR) when a notice of claim is submitted.

3. Forward all itemized bills and primary insurer's Explanation of Benefits forms (EOBs) to the claims administrator (HSR).

4. Download/review claim/loss reports to confirm claims are paid accordingly.

MUTUAL of OMAHA

3300 Mutual of Omaha Plaza
Omaha, NE 68175

CATASTROPHIC INJURY BLANKET INSURANCE POLICY

POLICY NUMBER: SB04CC-P-33898

POLICYHOLDER: **NATIONAL COLLEGIATE ATHLETIC ASSOCIATION ("NCAA")**
700 W. Washington Street
Indianapolis, IN 46206

(Hereinafter called the Policyholder)

EFFECTIVE DATE OF THIS POLICY: August 1, 2023

SUBJECT TO THE TERMS AND CONDITIONS IN THIS Policy, and in return for the payment of premium and the signed application, Mutual of Omaha Insurance Company (hereinafter referred to as the "Company") issues this Policy to the Policyholder and agrees that on and after the Effective Date of this Policy, it will provide the insurance herein described for Insured Persons. The Company and the Policyholder have agreed to all terms of this Policy.

This Policy shall be effective at 12:01 a.m., Eastern Standard Time, on August 1, 2023, and shall end at 12:01 a.m., Eastern Standard Time, on August 1, 2024 (the "Policy Term"). Coverage during the Policy Term is subject to the Contingent Pricing Feature and payment of the premium as set forth in the Premium section (Section X) and all other terms and conditions of this Policy.

This Policy is delivered in the state of Indiana and is governed by its laws, without regard to Indiana's principles of conflicts of laws.

Mutual of Omaha Insurance Company has caused this Policy to be executed on August 1, 2023.

James T. Blackledge — Chief Executive Officer

Jay A. Vanbeat — Corporate Secretary

Table of Contents

SECTION I - SCHEDULE OF BENEFITS

All benefits described in this Policy are subject to the applicable limits as described in this Schedule of Benefits.

A. For all benefits under Section III - Medical, Dental, Rehabilitation and Custodial Care Expense Benefits, Section IV - Disability Benefits and Section V - Ancillary Benefits, combined:

Maximum Benefit Amount per Insured Person per Covered Accident:	$20,000,000

B. Medical, Dental, Rehabilitation and Custodial Care Expense Benefits

1. For those Insured Persons who Incur a Covered Loss in excess of the Covered Accident Deductible, this Policy will provide the Medical, Dental, Rehabilitation and Custodial Care Expense Benefits described in Section III.

Custodial Care Maximum Benefit per Calendar Year subject to the Combined Home Health Care and Custodial Care Maximum Benefit per Calendar Year	$100,000*
Home Health Care Maximum Benefit per Calendar Year subject to the Combined Home Health Care and Custodial Care Maximum Benefit per Calendar Year	$100,000*
Combined Home Health Care and Custodial Care Maximum Benefit per Calendar Year	$100,000*
Private Duty Nursing Maximum Benefit per Calendar Year subject to the Combined Private Duty Nursing and Combined Home Health Care and Custodial Care Maximum Benefit per Calendar Year	$250,000
Combined Private Duty Nursing, Custodial Care and Home Health Care Maximum Benefit per Calendar Year	$250,000
Maximum Benefit Period	Lifetime
Benefit Percentage after satisfaction of the Covered Accident Deductible	100%
Covered Accident Deductible	$90,000

For injuries Incurred during the 2023-2024 policy term:
*Beginning January 1, 2024 and effective January 1 of each year thereafter this maximum benefit will increase annually. The amount of the increase will be equal to the lesser of:

(a) 2%; or
(b) the percentage of increase, if any, in the Consumer Price Index for Urban Wage Earners and Clerical Workers, based on the year-over-year change reported as of the immediately preceding November.

2. Payment for covered Medical Expense resulting from a Covered Accident for care and treatment of mental or nervous disorders by a Doctor shall not exceed $90.00 for each visit, not more than one visit on any one day, nor more than fifty (50) visits in each calendar year. Covered Medical Expense for Hospital inpatient care or treatment of a mental or nervous disorder whether in a general Hospital or a psychiatric Hospital, will be limited to the first forty-five (45) days of such treatment during each calendar year. For Partial Hospitalization for care or treatment of a mental or nervous disorder, each two (2) days of Partial Hospitalization will be treated as one (1) day of inpatient hospitalization for purposes of accumulating the forty-five (45) days of inpatient treatment maximum per calendar year. These limitations for mental or nervous disorders will not apply when the primary condition requiring such care and treatment is due to a brain Injury Incurred as the result of a Covered Accident.

3. Outpatient Physical Therapy Benefit Maximum $75,000 per calendar year

Payment for outpatient physical therapy must qualify as a Rehabilitation Expense. Outpatient physical therapy includes, but is not limited to: (a) heat treatment; (b) diathermy; (c) microtherm; (d) ultrasonic; (e) adjustment; (f) manipulation; (g) massage therapy; and (h) acupuncture.

If surgical treatment is rendered while the patient is under general anesthesia, this limitation shall not apply to covered Medical Expense for treatment of subluxation or dislocation of the spine or treatment for the general purpose of

correction of nerve interference and its effects, by manual or mechanical means when interference results from or is related to distortion or misalignment of or in the vertebral column.

4. Payment for all prosthetic devices/limbs, including adjustments, replacements, refittings and supplies, in combination, shall not exceed $100,000 during the first two (2) years after the Covered Accident. Payment shall not exceed $100,000 ($200,000 if the Covered Accident results in an amputation of the leg above the knee) during each consecutive ten (10) year period immediately thereafter, not to exceed a $500,000 Lifetime maximum ($750,000 Lifetime maximum if the Covered Accident results in an amputation of the leg above the knee).

5. Payment for covered Medical Expenses Incurred within 24 months following the Date of Recovery of a Covered Accident shall not exceed $25,000.

C. Disability Benefits

For those Insured Persons who Incur a Covered Loss in excess of the Covered Accident Deductible, and who are Totally or Partially Disabled as defined herein, this Policy will provide:

1. Total Disability Benefit – $400 each month, not to exceed twelve (12) months, and $2,700 each month thereafter during which the Insured Person remains Totally Disabled. The $2,700 monthly Total Disability benefit amount will be increased by 3% after the $2,700 benefit has been paid for twelve (12) consecutive months and after each subsequent twelve (12) consecutive month period while the Insured Person remains Totally Disabled.

   Total Disability Benefit Offset Provision
   The monthly benefit for Total Disability will be reduced by one-half (1/2) of the after-tax monthly compensation earned by the Insured Person in excess of $1,000 per month beginning on the first anniversary after the date of the Covered Accident. That $1,000 will be increased by 2.5% each subsequent twelve (12) consecutive month period thereafter.

2. Partial Disability Benefit (for an Insured Person that has not previously received Total Disability benefits under this policy) $270 each month, not to exceed twelve (12) months, and $1,800 each month thereafter during which the Insured Person remains Partially Disabled. The $1,800 monthly Partial Disability benefit amount will be increased by 3% after that benefit has been paid for twelve (12) consecutive months and after each subsequent twelve (12) consecutive month period while the Insured Person remains Partially Disabled.

   Partial Disability Change in Status Benefit (for an Insured Person who previously received Total Disability benefits under this policy) - Maximum initial monthly benefit for continuous Partial Disability is 2/3 of the Total Disability Benefit that was paid for the month immediately preceding the change in status to Partial Disability. The monthly Partial Disability benefit amount will be increased by 3% after that benefit has been paid for twelve (12) consecutive months and after each subsequent twelve (12) consecutive month period while the Insured Person remains Partially Disabled.

   Partial Disability Benefit Offset Provision
   The monthly benefit for Partial Disability will be reduced by one-half (1/2) of the after-tax monthly compensation earned by the Insured Person in excess of $1,400 per month beginning on the first anniversary after the date of the Covered Accident. That $1,400 will be increased by 2.5% each subsequent twelve (12) consecutive month period thereafter.

3. Adjustment Expense Benefit Maximum: $50,000 Lifetime

   a. Payment for expense of training of Immediate Family members to perform rehabilitative or custodial functions for the Insured Person shall not exceed $5,000, and such training must be rendered during the twenty-four (24) consecutive month period immediately following the date of the Covered Accident which necessitates such training.
   b. Payment will be made for travel of Immediate Family members which occurs within the period of twenty-four (24) consecutive months immediately following the date of the Covered Accident to the Insured Person which necessitates such family travel and shall not exceed $6,000 for each Immediate Family member who actually travels to the Hospital or Rehabilitation Facility.
   c. Loss of earnings by the Insured Person's spouse, or parent/legal guardian if the Insured Person is not married, will be limited to 75% of gross lost earnings of the spouse or one parent/guardian only due to the Injury to the Insured Person, not to exceed $500 per week for a maximum of twenty-six (26) weeks during the twenty-four (24) consecutive months immediately following the date of the Covered Accident. Gross earnings will be determined based on the average monthly gross earnings for the twelve (12)-month period immediately preceding the date of the Covered Accident.

4. Special Expense Benefit:

Limit during first 10 years following the date of the Covered Accident	$175,000
Limit for years 10-20 following the date of the Covered Accident	$70,000
Limit for years 20-30 following the date of the Covered Accident	$85,000
Limit for years 30-40 following the date of the Covered Accident	$105,000
Limit for each ten-year period thereafter following the date of the Covered Accident	$125,000

5. Ancillary Injury Benefit: $2,000 per calendar year deductible
   Not to exceed a Lifetime Aggregate of $100,000
   Benefit Percentage 100%

6. College Education Benefit
   Maximum Lifetime Benefit $120,000

7. Vocational Rehabilitation Benefit $60,000 Lifetime

8. Assimilation Benefit Maximum Benefit $50,000 Lifetime

D. Death Benefit $25,000

E. Nonduplication of Benefits

If any item of expense is payable under more than one provision of this Policy, payment will be made only under the provision providing the greatest benefit.

SECTION II - DEFINITIONS

1. "Activities of Daily Living *(ADLs)*" means:

    a. transferring oneself (such as moving in or out of a bed or chair);
    b. dressing (putting on or removing from oneself items of clothing);
    c. bathing (washing oneself in a bathtub or shower or by sponge bath);
    d. feeding (giving oneself food or nourishment, including through a feeding tube);
    e. toileting (getting oneself on or off a toilet and related hygiene); and
    f. continence (maintaining one's control of bladder or bowel functions or maintaining care of a catheter or colostomy bag if one cannot control bladder or bowel functions).

2. "Conditioning" means exercise, performed outside of practice sessions, that directly contributes towards the Insured Person's ability to participate as a player on an athletic team in a Qualifying Intercollegiate Sport. The exercise must take place at the Participating School's athletic facilities or another facility specifically authorized by the Participating School.

3. "Covered Accident" means an accident that occurs while this Policy is in effect, which directly results in bodily injury or death (not excluded from coverage by the Policy Exclusions and Limitations) of an Insured Person, and which:

    a. occurs while he or she is participating in a Covered Event; or
    b. occurs during Covered Travel to or from the location of a Covered Event; or
    c. occurs during a temporary stay at the location of a Covered Event held away from the location of the Insured Person's Participating School while the Insured Person is engaged in an activity or travel that is authorized by, organized by or directly supervised by an official representative of the Insured Person's Participating School; or
    d. results from a cardiovascular accident or stroke or other similar traumatic event caused by exertion while participating in a Covered Event; and;
    e. for which the Insured Person Incurs a Covered Loss, within twenty-four (24) consecutive months immediately following the date of the accident, in excess of the Covered Accident Deductible; or
    f. that results directly in the death (not excluded from coverage by the Policy Exclusions and Limitations) of the Insured Person within twenty-four (24) consecutive months immediately following the date of that accident.

4. "Covered Accident Deductible" means an amount of Medical Expenses and/or Dental Expenses and/or Rehabilitation Expenses and/or Custodial Care Expenses, as shown in the Schedule of Benefits, Incurred by the Insured Person as a result of a Covered Accident within the period of twenty-four (24) consecutive months immediately following the date of that Covered Accident, for which no benefits are payable under this Policy. Such expenses must qualify as Covered Loss under this Policy.

5. "Covered Event" means, for players on an athletic team:

    a. Qualifying Intercollegiate Sport competition scheduled by the Insured Person's Participating School;
    b. official team activities;
    c. conditioning; or
    d. practice sessions.

    For players on an athletic team, Covered Event must be authorized by, organized by or directly supervised by an official representative of the Insured Person's Participating School (not including any activities not directly a part of a Qualifying Intercollegiate Sport, such as camps, clinics and other events not conducted by the Insured Person's Participating School).

    Covered Event means, for Student coaches, Student managers and Student trainers, only those activities directly associated with the covered activities of a Qualifying Intercollegiate Sport team or covered activities of Student cheerleaders and under the direct supervision of an official representative of the Participating School.

    Covered Event means, for Student cheerleaders:

    a. activities performed as part of the cheer unit for a Qualifying Intercollegiate Sport team competition scheduled by the Insured Person's Participating School; or
    b. practice sessions and pep rallies both of which must be authorized by, organized by and directly supervised by a safety-certified official coach or advisor of the Insured Person's Participating School, other than a member of the cheer unit or other undergraduate Student, and in preparation for a Qualifying Intercollegiate Sport team competition. The coach or advisor

must have a current safety certification by a nationally recognized formal credentialing program for safety certification. However, the safety-certification requirement does not apply with respect to practice sessions that are held solely by dance team members or mascots. A graduate Student can meet the safety-certification requirement if:

i. officially designated by the school as the official coach or advisor; and
ii. the school has given the graduate Student the authority to authorize, organize and directly supervise.

For Student cheerleaders, Covered Event does not include any activities not directly associated with the activities of a Qualifying Intercollegiate Sport team, such as camps, clinics, national competitions, fund-raisers, alumni events and other events not conducted by the Insured Person's Participating School.

6. "Covered Loss" means Reasonable and Customary:

a. Medical Expense;
b. Dental Expense;
c. Rehabilitation Expense;
d. Custodial Care Expense;
e. Adjustment Expense;
f. Special Expense;
g. Medical Expense and Dental Expense that are covered under the Ancillary Injury Benefit; and
h. Expenses that are covered under the Vocational Rehabilitation Benefit as described in this Policy, which are Incurred by an Insured Person as a result of a Covered Accident.

Covered Loss shall also include the:

a. cost of school attendance that is covered under the College Education Benefit, and
b. program expenses covered under the Assimilation Benefit as described in this Policy, which are Incurred by an Insured Person as a result of a Covered Accident.

An expense will be a Covered Loss under this Policy after all adjustments (including, but not limited to, discounts, write- offs, and negotiated fees) have been applied only to the extent that the expense is for Medically Necessary services, and not excluded under Exclusions and Limitations (Section VIII) in this Policy. Further, for those Insured Persons who have satisfied the Covered Accident Deductible, Covered Loss shall not include any expenses sustained after the respective Date of Recovery (except as shown on the Schedule of Benefits, Section B-5).

7. "Covered Travel" means team or individual travel, for purposes of representing the Participating School, that is to or from the location of a Covered Event and is authorized by the Insured Person's Participating School, provided the travel is paid for or subject to reimbursement by the Participating School. Covered Travel to a Covered Event will commence upon embarkation from an authorized departure point and terminate upon arrival at the location of the Covered Event.

Covered Travel from a Covered Event will commence upon departing from the location of the Covered Event and terminate upon return to the authorized place from which such Covered Travel to the Covered Event began.

8. "Custodial Care" means Medically Necessary services or treatment which, regardless of where provided:

a. Could be rendered safely by a person without medical skills; and
b. Provide a routine level of maintenance care designed primarily to help the patient with daily living activities, including (but not limited to):
    i. Personal care such as help in walking; moving; getting in or out of bed; help with bathing; help with eating by spoon; tube or gastrostomy; dressing; enema and using the toilet;
    ii. Homemaking such as preparing meals or special diets;
    iii. Acting as a companion or sitter or providing a protective environment;
    iv. Supervising medication which can usually be self-administered;
    v. Oral hygiene; and
    vi. Ordinary skin and nail care; or
c. In the case of a Totally Disabled Insured Person, cannot be self-administered.

Custodial Care does not include exercise, physical therapy, occupational therapy or rehabilitation services or treatment, including those that may be payable under this Policy as a Rehabilitation Expense.

No benefits will be paid for Custodial Care services or treatment which is provided by a member of the Insured Person's Immediate Family or by an individual who resides with the Insured Person, unless specifically agreed to in writing by the Company. Custodial Care does not include Home Health Care services or treatment.

9. “Custodial Care Expense” means the Reasonable and Customary charges for Custodial Care services or treatment.

10. “Date of Recovery” means:

    a. for an Insured Person who suffered the complete and irreparable severance of an arm or leg at or above the wrist or ankle joint, but who was not Totally Disabled, the date immediately following a period of twenty-four (24) consecutive months during which the Insured Person received no Medically Necessary treatment or service as a result of the Covered Accident for which benefits had been received under this Policy;
    b. for an Insured Person not Totally Disabled and who has not suffered the complete and irreparable severance of an arm or leg at or above the wrist or ankle joint, the earlier of:
        i. the date the Insured Person receives medical clearance to participate in Qualifying Intercollegiate Sports; or
        ii. the date immediately following a period of **“**twenty-four” (24) consecutive months during which the Insured Person received no Medically Necessary treatment or service as a result of the Covered Accident for which benefits had been received under this Policy; or
    c. For an Insured Person who was Totally Disabled, the date such Insured Person no longer qualifies as Totally Disabled as defined herein, subject to 10.b. above.

11. “ Dental Expense” means the Reasonable and Customary charges for the Medically Necessary repair or replacement of sound, natural teeth.

12. “Doctor” means a duly licensed medical or dental practitioner who provides services or treatment within the scope of his or her license.

13. “Effective Date of Participation” means August 1, 2023, or August 1 of the year in which the college or university becomes a Participating School, if later.

14. "Experimental or Investigational Drug or Treatment" means a drug, device, treatment or procedure:

    a. which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and which has not been so approved for marketing at the time the drug, device, treatment or procedure is furnished;
    b. which was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility’s Institutional Review Board or other body serving a similar function, or a drug, device, treatment or procedure which is used with a patient informed consent document which was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility’s Institutional Review Board or other body serving a similar function;
    c. which Reliable Evidence shows is the subject of ongoing phase I, II or III clinical trials, or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis; or
    d. for which the prevailing opinion among experts, as shown by Reliable Evidence, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

    “Reliable Evidence” means only published reports and articles in peer-reviewed medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, treatment or procedure; or the patient informed consent document used by the treating facility or by another facility studying substantially the same drug, device, treatment or procedure.

15. “Extended Care Facility” means an institution operating pursuant to applicable state law which is engaged in providing, for a fee, skilled nursing care and related services and physical therapy services under the supervision of a Doctor and Registered Nurses, to persons convalescing from illness or injury. It must have facilities for ten (10) or more inpatients and maintain clerical records on all of its patients. To qualify as a “Medical Expense” under this Policy, the Insured Person’s confinement in an Extended Care Facility must:
    a. start within five (5) days after the Insured Person has been continuously confined for at least five (5) days in a Hospital as a result of a Covered Accident;
    b. be for treatment of the injuries resulting from such Covered Accident;
    c. be one during which a Doctor visits the Insured Person at least once every thirty (30) days;
    d. be certified to be Medically Necessary; and
    e. not be for Custodial Care.

16. "Home Health Care" means nursing care and treatment provided to an Insured Person in his/her home, which: (a) is required for progressive and positive improvement of the Insured Person's medical condition, or (b) is necessary to provide care and treatment that cannot be self-administered for a Totally Disabled Insured Person. To qualify for Home Health Care:

    a. A Home Health Care plan must be established and approved in writing by the attending Doctor, including certification in writing by the attending Doctor that confinement in a Hospital or Extended Care Facility would be required in the absence of Home Health Care; and
    b. Nursing care and treatment must be provided by a Hospital certified to provide Home Health Care services or by a certified Home Health Care agency; and
    c. Home Health Care must commence within seven (7) days of discharge from a Hospital or Extended Care Facility or Rehabilitation Facility and be immediately preceded by a Hospital or Extended Care Facility or Rehabilitation Facility confinement of five (5) consecutive days or more; and
    d. Home physical, speech, and occupational therapies must be initiated in conjunction with discharge placement through a Rehabilitation Facility and approved by the attending Doctor.

    No benefits will be paid for Home Health Care which is provided by a member of the Insured Person's Immediate Family or by an individual who resides with the Insured Person, unless specifically agreed to in writing by the Company. Home Health Care does not include Custodial Care or Private Duty Nursing.

17. "Hospice Care" means care and support provided to an Insured Person who is terminally ill (a life expectancy of six (6) months or less, if the illness runs its normal course) and their families, which focuses on palliative care rather than treatment of the Insured Person's illness. To qualify for Hospice Care:

    a. A Hospice Care plan must be established and approved in writing by the attending Doctor, including certification in writing by the attending Doctor that the Insured Person is terminally ill (expected to live six (6) months or less); and
    b. Hospice Care must be provided by a certified Hospice provider; and
    c. the Insured Person must accept palliative care instead of care to cure their illness.

    Hospice Care can be given in the home or in an inpatient facility, depending on the Hospice Care plan.

18. "Hospital" means an institution, which meets all of the following requirements:

    a. it is licensed (if required by law) as a hospital by applicable licensing authorities; and
    b. it is open at all times; and
    c. it is operated mainly to diagnose and treat illnesses on an inpatient basis; and
    d. it has a staff of one (1) or more Doctors on call at all times; and
    e. it has twenty-four (24) hour nursing services by Registered Nurses; and
    f. it is not mainly a skilled nursing facility, clinic, nursing home, rest home, convalescence home, or like place; and
    g. it has organized facilities for major surgery or provides for such facilities for its patients through formal written agreement with other Hospitals.

19. "Immediate Family" means the mother, father, sister, brother, husband, wife, or children of the Insured Person, who are members of the same household as the Insured Person. In their absence, others that may be considered as "Immediate Family" are grandparents, aunts or uncles, who share the same household, or any other person legally responsible for the care of the Insured Person.

20. "Incur" or "Incurred" means that an expense is sustained by the Insured Person, after all adjustments (including, but not limited to, discounts, write-offs and negotiated fees). A Covered Loss shall be considered to be Incurred on the date the treatment or service is rendered or the purchase or rental occurs.

21. "Injury or Injuries" means, bodily harm which:

    a. requires treatment by a Physician;
    b. results in loss due to an accident, independent of sickness and all other causes; and
    c. occurs during a Covered Event.

    Bodily Harm does not include pre-existing condition or a repetitive motion injury.

22. "Instrumental Activities of Daily Living (IADLs)" means:

    a. using the telephone and other communication devices;
    b. shopping;
    c. preparing meals;
    d. housekeeping or basic home maintenance;
    e. doing laundry;
    f. driving or arranging transportation;
    g. self-administering medication(s);
    h. handling finances.

23. "Insured Person" means:

    a. a Student attending or registered to attend the Participating School and participating as:
        i. a player on an athletic team in a Qualifying Intercollegiate Sport sanctioned and recognized by the Participating School; or as
        ii. a Student cheerleader of a cheer team officially recognized as such by the Participating School (includes dance team members and mascots); or as
        iii. a Student coach, Student manager, or Student trainer of an athletic team in a Qualifying Intercollegiate Sport sanctioned and recognized by the Participating School or of a cheerleading unit officially recognized as such by the Participating School;
    b. a person as identified by the Participating School and as approved in writing by the Company and endorsed onto this Policy; or
    c. a prospective student that has graduated from high school and signed an irrevocable commitment to participate in a Qualifying Intercollegiate Sport (or its equivalent for cheerleading) at a Participating School.

24. "Licensed Practical Nurse" means a licensed nurse practicing within the scope of his or her license under the direction of a Doctor or Registered Nurse.

25. "Lifetime" means the duration of the Insured Person's life, subject to all terms and conditions of the Policy including without limitation, the Date of Recovery definition.

26. "Medical Expense" means the Reasonable and Customary charges:

    a. of a professional ambulance service for Medically Necessary transportation to and from a Hospital;
    b. of a Doctor for Medically Necessary care and treatment;
    c. of a Hospital for Medically Necessary inpatient services, including room and board (not exceeding the semi-private room rate for each day of confinement unless a private room is Medically Necessary);
    d. for Medically Necessary Hospital inpatient services and supplies, including intensive care services, and daily Hospital charges for personal Hospital services (including television, radio, telephone, barber, and beauty services to a maximum payment of $300 per month);
    e. for Medically Necessary out-patient and emergency room care and treatment;
    f. for confinement in an Extended Care Facility;
    g. for Home Health Care;
    h. for Private Duty Nursing; and
    i. for medical or surgical services, prescription drugs, and other medical supplies commonly used for therapeutic or diagnostic services, which are Medically Necessary and prescribed by a Doctor operating within the scope of his or her license.

27. "Medically Necessary" means a service or supply that is ordered, prescribed or rendered by a Doctor or Hospital and determined by the Company to be:

    a. provided for the diagnosis or treatment of the patient's condition; and
    b. appropriate and consistent with the symptoms and findings or diagnosis and treatment of the Insured Person's condition; and
    c. provided in accordance with generally accepted professional standards and/or medical practice; and
    d. the most appropriate supply or level of service which can be provided on a cost effective basis (including but not limited to, inpatient vs. outpatient care, electric vs. manual wheelchair, surgical vs. medical or other types of care).

In the case of Hospital or Extended Care Facility confinement, Home Health Care or Private Duty Nursing or Custodial Care, the length of confinement or treatment and the services or supplies furnished by the Hospital or Extended Care Facility, Home Health Care or Private Duty Nursing or Custodial Care plan will be Medically Necessary only if it is reasonably determined by the Company that they are related to the care or treatment of the patient's condition. The services or supplies must not be an Experimental or

Investigational Drug or Treatment in nature. The fact that a Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.
In the case of Hospice Care, the length of care and the services or supplies furnished by the Hospice Care provider or Hospice Care plan will be considered Medically Necessary if it reasonably meets the definition of Hospice Care as defined in this policy.

28. "Partial Disability or Partially Disabled" means the Insured Person, within two years of the date of a Covered Accident and as a result of that Covered Accident:

    a. has suffered an irrecoverable loss of use of both arms, use of both legs, or use of one arm and one leg and is unable to perform at least one ADL(s); or
    b. has suffered an irrecoverable loss of speech, hearing of both ears or sight in both eyes and is unable to perform at least one ADL(s) or at least one IADL(s); or
    c. has suffered severely diminished mental capacity due to brain stem or other neurological damage and is unable to perform at least one ADL(s) or at least two IADL(s).

29. "Partial Hospitalization" means at least three (3) hours of continuous care and treatment in a Hospital, but not more than twelve (12) hours of such care and treatment in any twenty-four (24) hour period.

30. "Participating School" means a college or university, which is an active member of the NCAA. For purposes of this policy, a provisional member of the NCAA that becomes an active member of the NCAA during the August 1, 2023 to August 1, 2024 School Year, will be considered an active member of the NCAA on August 1, 2023.

31. "Private Duty Nursing" means Medically Necessary services or treatment received immediately after discharge from a Hospital or Extended Care Facility that is:

    a. rendered by a Registered Nurse or Licensed Practical Nurse who is licensed in the state where he or she is practicing; and
    b. provided during a scheduled shift as opposed to intermittent skilled Home Health Care.

    No benefits will be paid for Private Duty Nursing provided by a member of the Insured Person's Immediate Family or by an individual who resides with the Insured Person, unless specifically agreed to in writing by the Company. Private Duty Nursing does not include Home Health Care or any services or treatment provided in a Hospital or in an Extended Care Facility.

32. "Qualifying Intercollegiate Sport" means a sport:

    a. which has been accorded varsity status by the Participating School as an NCAA sport; and
    b. which is administered by such school's department of intercollegiate athletics; and
    c. for which the eligibility of the participating Student athlete is reviewed and certified in accordance with NCAA legislation, rules, or regulations; and
    d. which entitles qualified participants to receive the Participating School's official awards.

33. "Reasonable and Customary" means an expense that is determined by the Company not to exceed the amount usually charged by most providers in the same geographic area for similar treatment, service, purchase or rental, taking into account the nature and severity of the illness or injury.

    The same geographic area means the same city or town in which the treatment, service, or purchase occurs, if the city or town is large enough to obtain a representative charge. In large cities, it may be a section or sections of the city. In smaller urban or rural areas, the geographic area will be expanded as necessary to obtain a representative charge.

34. "Registered Nurse" means a professional, licensed, graduate registered nurse, practicing within the scope of his or her license.

35. "Rehabilitation Expense" means the Reasonable and Customary charges for Medically Necessary physical and occupational rehabilitation provided:

    a. by a Doctor;
    b. under the supervision of a duly licensed Rehabilitation Facility; or
    c. by an individual with an accredited certification in fitness, strength training, conditioning, sports medicine or related therapy, including (but not limited to) Certified Strength and Conditioning Specialists and Certified Personal Trainers.

36. "Rehabilitation Facility" means a legally operating institution or part of an institution which has a transfer agreement with one or more Hospitals and which is primarily engaged in providing comprehensive multi-disciplinary physical rehabilitative services or physical rehabilitation inpatient care and is duly licensed by the appropriate government agency to provide such services. Such facility is required to be accredited by the Joint Commission on Accreditation of Hospitals, or the Commission on Accreditation of Rehabilitation Facilities. "Rehabilitation Facility" does not include an institution which provides only minimal care, Custodial Care, care for the terminally ill, or part-time care services; nor an institution which primarily provides treatment for mental disorders, chemical dependency, or tuberculosis, unless such facility is licensed, certified, or approved as a rehabilitation facility for the treatment of medical conditions, drug addictions, or alcoholism in the jurisdiction where it is located. A Rehabilitation Facility is required to be accredited by the Joint Commission on Accreditation of Hospitals, or the Commission on Accreditation of Rehabilitation Facilities.

37. "School Year" means the one-year period beginning at 12:01 a.m., Eastern Standard Time, on August 1 and ending at 12:01 a.m., Eastern Standard Time, on the following August 1.

38. "Student" means an individual who is actually enrolled and attending school as a full time Student at a Participating School, or recognized as a full time Student by a Participating School.

39. "Total Disability or Totally Disabled" means the Insured Person, within two years of the date of a Covered Accident and as a result of that Covered Accident:

    a. has suffered an irrecoverable loss of use of both arms, use of both legs, or use of one arm and one leg and is unable to perform at least three ADL(s); or
    b. has suffered an irrecoverable loss of speech, hearing of both ears, or sight in both eyes and is unable to perform at least three ADL(s) or at least three IADL(s); or
    c. has suffered severely diminished mental capacity due to brain stem or other neurological damage and is unable to perform at least three ADL(s) or at least four IADL(s).

40. "True Catastrophic Claim" means a covered claim for an Insured Person who is either Totally Disabled or Partially Disabled. True Catastrophic Claim also includes a covered claim for an Insured Person with one or more limbs amputated because of a Covered Accident.

SECTION III - MEDICAL, DENTAL, REHABILITATION AND CUSTODIAL CARE EXPENSE BENEFITS

Benefits will be paid under this Policy, subject to the Maximum Benefit Amount shown in Section A of the Schedule of Benefits, on an excess basis as provided in Section VI "Other Insurance" for Covered Loss which is Incurred by the Insured Person after the date the Covered Accident Deductible has been satisfied. The Covered Accident Deductible will be satisfied on the date the Insured Person Incurs Covered Loss in the form of Medical Expenses and/or Dental Expenses and/or Rehabilitation Expenses and/or Custodial Care Expenses which exceed the Covered Accident Deductible.

An expense will be a Covered Loss under this Policy only to the extent it is Reasonable and Customary and only to the extent that it is for Medically Necessary services and supplies described in this Policy and not excluded under Exclusions and Limitations (Section VIII) in this Policy.

SECTION IV - DISABILITY BENEFITS

All benefits payable under this Section IV will be subject to the Maximum Benefit Amount shown in Section A of the Schedule of Benefits.

We will pay benefits, commencing on the first day of the month following the date of the Covered Accident, to a Partially or Totally Disabled Insured Person who:

- has satisfied the Covered Accident Deductible;
- has Injuries that are expected to be of a continuous and indefinite duration, as certified in writing by a Doctor We approved; and
- is under the continuous care of a Doctor for his or her Injuries, unless the Insured Person has reached his or her maximum point of recovery as certified in writing by a Doctor We approved.

Total Disability Benefits
We will pay Total Disability benefits in the amount shown on the Schedule.

Total Disability benefits will end on the earliest of:

- the expiration of the Maximum Benefit Period shown on the Schedule;
- the date the Insured Person is no longer Totally Disabled; or
- the date, beginning on the first anniversary date following the date of the Covered Accident, that the Insured Person's average gross monthly earnings for six (6) consecutive months exceed $3,500 per month. That $3,500 will be increased by 2.5% after each subsequent twelve (12) consecutive month period thereafter.

Partial Disability Benefits
We will pay Partial Disability benefits in the amount shown on the Schedule.

Partial Disability benefits will end on the earliest of:

- the expiration of the Maximum Benefit Period shown on the Schedule;
- the date the Insured is no longer Partially Disabled; or
- the date, beginning on the first anniversary date following the date of the Covered Accident, that the Insured Person's average gross monthly earnings for six (6) consecutive months, exceeds $3,500 per month. That $3,500 will be increased by 2.5% after each subsequent twelve (12) consecutive month period thereafter**.**

SECTION V - ANCILLARY BENEFITS

All benefits payable under this Section V will be subject to the Maximum Benefit Amount shown in Section A of the Schedule of Benefits.

A. Adjustment Expense Benefits

Adjustment Expense Benefits, subject to the limits described in the Schedule of Benefits, are payable for certain Reasonable and Customary Adjustment Expenses Incurred, provided the Covered Accident Deductible is satisfied by an Insured Person who is Totally or Partially Disabled. Adjustment Expenses include:

1. Training of members of the Immediate Family of the Insured Person to perform rehabilitative or custodial functions necessary for rehabilitation or care of the Insured Person;
2. Family travel for an Insured Person's Immediate Family. Family travel will be limited to travel by members of the Insured Person's Immediate Family to and from the location at which the Insured Person is receiving treatment in a Hospital or Rehabilitation Facility. Family travel must be by regularly scheduled commercial airline, train, bus, or personal automobile. The expense of "family travel" includes the expense of general coach fares, and reasonable expense for lodging, meals, and car rental for members of the Insured Person's Immediate Family. Personal automobile expenses for family travel will be limited to the prevailing Internal Revenue Service rate (based upon cents per mile) to the location of the Hospital or Rehabilitation Facility. Family travel does not include the expense of clothing, tips, travel other than to the Hospital or Rehabilitation Facility, or any other item or service beyond that described herein; and
3. If the Insured Person's spouse, or if the Insured Person is not married, the Insured Person's parent or other person legally responsible sustains a loss of earnings as a result of missing regular employment to travel to the location at which the Insured Person is receiving treatment, such loss of earnings shall be recoverable hereunder, subject to the limits shown in Section I, Schedule of Benefits.

B. Special Expense Benefits

Special Expense Benefits are payable for Reasonable and Customary expenses Incurred, after the Covered Accident Deductible has been satisfied, by an Insured Person who is Totally or Partially Disabled as a result of a Covered Accident for special items approved by the Insured Person's Doctor and are Medically Necessary to accommodate his or her physical disability, such as specialized wheelchair or other types of equipment or computer programs designed for use by someone with the type of physical disability suffered by the Insured Person, purchase of a motor vehicle, the adaptation or modification in design and/or equipment of the Insured Person's owned motor vehicle or such motor vehicle as is customarily at the disposal of or in the usual possession of the Insured Person, or for adaptation or modification of the Insured Person's housing in design and/or equipment. Special Expense Benefits are subject to the limits described in the Schedule of Benefits. Such item or modification must be approved by the Doctor as being appropriate and as being Medically Necessary to accommodate the physical disability of the Insured Person as a result of a Covered Accident.

Payment for the purchase of a motor vehicle will be limited to those expenses reasonably necessary to provide a motor vehicle appropriate to accommodate the Insured Person and will be made only if the Insured Person's then existing motor vehicle cannot be modified to accommodate the Insured Person's physical disability; however, payment for purchase or modifications of a motor vehicle, specialized wheelchair or housing will be limited to only such purchase and modification(s) which are appropriate to accommodate the Insured Person's physical disability as recommended by the Insured Person's Doctor and approved by the Company.

C. Ancillary Injury Benefits

1. Ancillary Injury Benefits are payable for Medical Expenses and Dental Expenses, subject to the limits shown in the Schedule of Benefits, Section I.
2. Such expenses must be Incurred as a result of an accidental bodily injury to a Totally or Partially Disabled Insured Person which occurs during the period he or she is receiving Total or Partial Disability Benefits in connection with a Covered Accident, and which results from a separate accident unrelated to such Covered Accident.

D. College Education Benefit

The College Education Benefit provides payment, in accordance with the time limitations described below, for the full standard cost of attendance for a Totally or Partially Disabled Insured Person to complete his or her undergraduate and/or graduate degree at the school such person was attending at the time of the Covered Accident or at an alternate institution provided, however, that the amount of the College Education benefit payable for undergraduate study shall not exceed the comparable full standard cost of

attendance otherwise payable for undergraduate study at the school attended at the time of the Covered Accident or the Maximum Lifetime Benefit shown in Section I, Schedule of Benefits, whichever is less. The full standard cost of attendance shall be as determined by the financial aid office at the particular school net of any other financial aid received by the Insured Person.

The College Education Benefit for those eligible Insured Persons whose full standard cost of attendance continues to be funded through his or her athletic or other scholarship will not commence until the expiration of any athletic or other scholarship provided to the Insured Person by the Participating School. Benefits that are payable will be paid directly to the school as the payment is due.

To qualify for the College Education Benefit, the Totally or Partially Disabled Insured Person must recommence studies within five (5) years from the date the Covered Accident occurred. The College Education Benefit will terminate at the earliest of:

1. the date the Insured Person completes the requirements for a graduate degree;
2. the twentieth (20^{th}) anniversary of the date the Insured Person first recommenced studies; or
3. the date the Maximum Lifetime Benefit shown in the Schedule of Benefits has been paid.

E. Vocational Rehabilitation Benefit

The Vocational Rehabilitation Benefit provides payment for Reasonable and Customary expenses for services rendered through a vocational rehabilitation program or for vocational rehabilitation counseling services intended to enable the Totally or Partially Disabled Insured Person to develop skills necessary for gainful employment, and to participate in a job search and find gainful employment. Benefits during the Insured Person's Lifetime shall not exceed the limit shown on the Schedule of Benefits.

F. Assimilation Benefit

The Assimilation Benefit provides for payment up to the Maximum Assimilation Benefit amount shown in the Schedule of Benefits for the Totally or Partially Disabled Insured Person to participate in a specialized, intensive, rehabilitation program at an accredited medical facility specializing in research, surgery, and training for injuries to the spinal cord, the nervous system, or closed head injuries.

Participation by the Totally or Partially Disabled Insured Person in an assimilation program eligible for benefits under this Policy must commence within two (2) years of the date of the Covered Accident. Assimilation Benefits payable will terminate on the earlier of:

1. the date the Totally or Partially Disabled Insured Person completes the assimilation program for which benefits are payable; or
2. the date the Maximum Assimilation Benefit has been paid.

Benefits will be paid directly to the facility providing the assimilation program as the payment is due, and only after participation has commenced by the Totally or Partially Disabled Insured Person. Benefits include reasonable travel expenses for the Insured Person and two (2) Immediate Family members. Benefits paid for travel expenses will be applied to and are subject to the Maximum Assimilation Benefit.

SECTION VI - DEATH BENEFIT

The Death Benefit shown in the Schedule of Benefits, Section I, will be paid if an Insured Person dies as a result of a Covered Accident.

Each Insured Person may designate a beneficiary to whom the death benefit shall be payable and may change the beneficiary designation. Any beneficiary designation or change will not take effect until a written request of such on a form satisfactory to the Company has been signed by the Insured Person and recorded by the Company or its authorized representative.

Whether or not the Insured Person is living, the designation or change of beneficiary, when properly signed and recorded, shall take effect from the date it is signed by the Insured Person. Any payment made by the Company prior to the date the beneficiary designation or change is recorded by the Company or its authorized representative shall release the Company from any further liability under this Policy, to the extent of such payment.

If the designated beneficiary of record does not survive the Insured Person or if the Insured Person fails to designate a beneficiary, payment of death benefits will be made to 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 person that is the legal guardian for the Insured Person; otherwise
e. the Insured Person's surviving brothers and/or sisters, equally.

If two or more beneficiaries of record are named, and if the Insured Person does not state their responsive interests, such beneficiaries shall share equally. If any of such beneficiaries die before the Insured Person, his or her interest will pass to the surviving beneficiary(ies) equally.

If any Death Benefit shall be payable to the estate of the Insured Person, or to a beneficiary who is a minor or otherwise unable to give a valid release, the Company may pay such Death Benefit, 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, after submission of evidence satisfactory to the Company of payment of medical or other expenses Incurred by or on behalf of the Insured Person, 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 Benefit provided hereunder may not be assigned, transferred, or encumbered, without the written consent of the Company, 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.

SECTION VII - OTHER INSURANCE - EXCESS NATURE OF POLICY

Except as provided below, this Policy is excess over any Other Insurance or similar benefit program available to the Insured Person for a Covered Loss under this Policy. If an Insured Person receives or is eligible to receive benefits or services from any Other Insurance or similar benefit program for any benefit category of a Covered Loss for which he or she is eligible under this Policy, such benefit under this Policy will be reduced by the amount of such Other Insurance or similar benefit program.

If an Insured Person is entitled to Other Insurance or similar benefit program for a benefit category of a Covered Loss for which he or she has been paid benefits under this Policy, the Insured Person will reimburse the Company to the extent of such benefits paid under this Policy, not to exceed the amount of Other Insurance or similar benefit program received or for which the Insured Person is eligible.

For purposes of this Policy, an Insured Person's eligibility for Other Insurance or similar benefit program will be determined as if this Policy did not exist and shall not depend upon whether application for Other Insurance or similar benefit program is made by or on behalf of the Insured Person.

"Other Insurance" means any reimbursement for or recovery of any element of Covered Loss available from any other source whatsoever, except gifts and donations, including without limitation:

a. any individual, group, blanket, or franchise policy of accident, or health insurance;
b. any arrangement of benefits for members of a group, whether insured or uninsured;
c. any prepaid service arrangement such as Blue Cross or Blue Shield, individual or group practice plans, or health maintenance organizations;
d. any amount payable for hospital, medical, or other health services for 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;
e. any amount payable for services for injuries or diseases related to the Insured Person's job to the extent that he or she actually receives benefits under a Worker's Compensation law. If the Insured Person enters into a settlement to give up his or her rights to recover future medical expenses under a Worker's Compensation Law, this Policy will not pay benefits for those medical expenses that would have been payable except for that settlement;
f. any benefits payable under any program provided or sponsored solely or primarily by any federal, state, or local governmental unit or agency or subdivision or through operation of law or regulation, except Medicaid; and
g. income received through a trust fund or similar arrangement, whether declared or not.

PROVIDED, however, that if an Insured Person is covered under a policy issued by another insurance carrier which provides catastrophic excess benefits similar to those provided under this Policy which are subject to a deductible of $50,000 or more, any benefits payable under such policy will not be regarded as Other Insurance or similar benefit program. Instead, this Policy, on an excess basis over all Other Insurance or similar benefit program, will share payment of Covered Loss with the other policy by contribution based on equal shares, after satisfaction of the Covered Accident Deductible. Under this approach, this Policy will contribute an amount equal to that contributed by the other catastrophic policy until the Covered Loss is paid.

SECTION VIII - SUBROGATION/RECOVERY RIGHTS

If the Insured Person has rights to recover from a third party all or part of any payment made under the terms of this Policy, those rights, are transferred to the Company, regardless of whether the Insured Person has been made whole or has received full compensation from or has been paid by the third party all losses sustained or alleged. The Insured Person must do nothing after the Covered Accident to impair such rights. The Insured Person will bring legal action or transfer those rights to the Company and help the Company enforce them.

Notwithstanding the foregoing, the Company shall be entitled to recover any benefits paid up to the amount of the "Net Recovery" by the Insured Person against any such third party. "Net Recovery" shall mean the gross recovery against the third party wrongdoer, less attorneys' fees and expenses and court costs.

Should any money be recovered by the Insured Person from an alleged third party wrongdoer for which benefits were paid under this Policy, the "Net Recovery" shall be considered Other Insurance for all purposes of this Policy.

The Insured Person shall notify the Company within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Insured Person's intention to pursue or investigate a claim to recover damages or obtain compensation relating to a Covered Accident for which the Company provided benefits. The Insured Person must provide all information requested by Company or its representatives including, but not limited to, completing and submitting any applications or other forms or statements as reasonably requested.

The Company agrees it will not seek subrogation against the NCAA, Participating School, or any NCAA member as defined in the NCAA bylaws.

The provisions of this Section shall not apply to Insured Persons residing in or attending Participating Schools located in states where this subrogation/recovery provision is prohibited by law.

SECTION IX - EXCLUSIONS AND LIMITATIONS

This Policy does not cover, and the Covered Accident Deductible may not be satisfied by, any Covered Loss, Total Disability, Partial Disability or death caused or contributed by or resulting from:

a. self- destruction or attempted self-destruction, while sane or insane, or intentional self-inflicted injury;
b. the Insured Person's commission of, or attempted commission of, a criminal or felonious act, EXCEPT this exclusion does not apply to bodily injury which occurs at the facility in which a Covered Event is being held and as a result of the Insured Person's participation in that Covered Event; or
c. the Insured Person being intoxicated, or being under the influence of drugs or narcotics unless as prescribed by a Doctor for a medical condition other than drug addiction, EXCEPT this exclusion does not apply to bodily injury which occurs at the facility in which a Covered Event is being held and as a result of the Insured Person's participation in that Covered Event.
An Insured Person shall be presumed to be intoxicated if the level of alcohol in his or her blood is determined to exceed the level above which a person is held under the law of the location at which the Covered Accident occurs, to be intoxicated if operating a motor vehicle, regardless of whether the Insured Person is in fact operating a motor vehicle when the Covered Accident occurs.
d. any injury or illness suffered by an Insured Person where the Insured Person's Participating School required the Insured Person to sign a waiver relieving that Participating School of responsibility or liability based on notification by a Doctor that the Insured Person's participation exposed the Insured Person to increased risk for that type of injury, cardiovascular accident or stroke or other similar traumatic event incurred.

This Policy does not cover, and the Covered Accident Deductible may not be satisfied by, disease or illness, EXCEPT:

a. as provided in the Ancillary Injury provision of the Policy; or
b. when treatment for a disease or illness is Medically Necessary and the disease or illness is a direct result of a Covered Accident; or
c. for a cardiovascular accident or stroke or other similar traumatic event caused by exertion while participating in a Covered Event.

SECTION X - PREMIUM

1. Computation of Premium

   Subject to the provisions of Paragraph 3. below, a single annual premium of $10,800,000 is due and payable in four quarterly installments for the 2023-2024 Policy Term at the Home Office of the Company as described in Paragraph 2. below. Failure to pay any installment when due shall constitute failure to pay the full annual premium.

2. Payment of Premium

   Subject to the provisions of Paragraphs 3 and 4 below, premiums are payable as follows:

   2023-2024 Policy Term:
   Initial quarterly installment of $2,700,000 is due by August 1, 2023;
   Second quarterly installment of $2,700,000 is due by November 1, 2023;
   Third quarterly installment of $2,700,000 is due by February 1, 2024;
   Fourth quarterly installment of $2,700,000 is due by May 1, 2024.

3. Premium Change

   The Company reserves the right to adjust the premium amount, after consultation with the Policyholder, in the event the number of Participating Schools falls below 1,000 or exceeds 1,200.

4. Contingent Pricing Feature

   If the first payment is made for six or more True Catastrophic Claims between 12:01am Eastern Standard Time on May 1, 2022, and 12:01am Eastern Standard Time on May 1, 2023, the Company reserves the option to increase the previously stated $10,800,000 annual premium for the 2023-2024 policy year.

   The Insured will be advised of any adjustment in the 2023-2024 premium at least 31 days prior to August 1, 2023.

5. In the event a national health care plan becomes effective in the United States during the term of this Policy which provides substantially the same benefits under substantially the same terms and conditions as provided hereunder, the Company agrees to recalculate and prorate the premium as of the next following August 1 for the then remaining term of the Policy, after consultation with the Policyholder (but consent of the Policyholder is not required), considering both the claims experience under this Policy to such date and the coverage provided under any such national health care plan.

SECTION XI - GENERAL PROVISIONS

1. Insurance Benefits

   Benefits for Insured Persons will be determined by the provisions of this Policy.

2. Notice of Claim

   a. Written notice of claim must be given to the Company or its authorized representative within sixty (60) days of the date of the Covered Loss, accidental death or commencement of Total Disability or Partial Disability. If notice is not given within sixty (60) days, a claim will not be denied or reduced for that reason if notice was given as soon as reasonably possible thereafter.
   b. When the Company or its authorized representative receives notice of claim, forms for filing proof of loss will be furnished to the Insured Person or, if the Insured Person is deceased, to his or her beneficiary. If these forms are not furnished to the Insured Person within fifteen (15) days from the date notice is received by the Company or its authorized representative, the Insured Person will have met the proof of loss requirements if written proof of loss is submitted within the time required in 3. below.

3. Proof of Loss

   a. Proof of loss for Hospital confinement must be given to the Company or its authorized representative within ninety (90) days after release from the Hospital.
   b. Proof of any other Covered Loss, Total Disability, Partial Disability or accidental death must be given to the Company or its authorized representative not later than ninety (90) days after the Covered Loss, accidental death or commencement of Total Disability or Partial Disability.
   c. If proof of any loss is not given within ninety (90) days, the claim will not be denied or reduced for that reason if that proof was given as soon as reasonably possible thereafter.
   d. “Proof” as required in this section, means proof satisfactory to the Company.

4. Physical Examination and Autopsy

   a. The Company, at its own expense, has the right to have an Insured Person examined, as often as it may reasonably require, whenever his or her loss is the basis of a claim.
   b. The Company has the right to require an autopsy of the Insured Person if not prohibited by law.

5. Payment of Claim

   Death benefits payable under this Policy will be paid in accordance with the beneficiary designation and the provisions respecting such payment set out herein and effective at the time of payment. Any other payable benefits, which remain unpaid at the time of the Insured Person's death, may at the option of the Company, be paid to the beneficiary or to the Insured Person’s estate.

   All other benefits will be payable to the Insured Person or the medical services provider if the Company has received a valid assignment by the Insured Person, unless the Company determines that the Insured Person is unable to receive such payment because he or she is not legally able to give a binding receipt for the payment. In the absence of a written assignment of benefits, all or a portion of these other benefits may be reimbursed to the provider rendering the service. Such payment will be at our option.

   If the Company determines that the Insured Person is not able to receive such payment, the Company may, at its option, pay the benefits to the Insured Person’s estate, spouse, the legal guardian for the Insured Person or to a court of competent jurisdiction.

   The Company reserves the right to allocate the Covered Accident Deductible to any Covered Loss and to apportion the benefits to the Insured Person and/or his or her assignees. Such action will be binding on the Insured Person and his or her assignees.

   Any payment made under this Section XI-5 will completely discharge the Company from further obligation for such payment.

6. Time of Payment of Claim

   Benefits will be paid as soon as the Company receives proper proof of loss unless this Policy provides for periodic payment. When this Policy provides for periodic payment, the benefits will be paid monthly subject to proper proof of loss.

7. Choice of Doctor

The Insured Person is free to be treated by any Doctor he or she chooses.

8. Workers' Compensation

This Policy is not a Workers' Compensation policy and is not intended to satisfy any requirements for coverage by Workers' Compensation insurance.

9. Legal Actions

No lawsuit may be brought to recover on this Policy within sixty (60) days after proof of loss has been given as required by this Policy. No lawsuit may be brought after three (3) years from the time written proof of loss is required to be given.

10. Statements

In the absence of fraud, all statements made by the Policyholder or by any Insured Person will be deemed representations and not warranties. No such representations will void the insurance or be used to deny a claim unless a copy of the instrument containing such representation is or has been furnished to the Insured Person.

11. Termination of Insurance

Neither the Company nor the Insured shall have the ability to terminate this agreement with the exception of the following circumstances:

A. The Policyholder may terminate this agreement at any time by providing ten (10) days notice in writing to the Company, upon the occurrence of any one of the following circumstances:
    1. A premium increase by the Company exceeding $10,800,000 for Policy Term 2023-2024.
    2. The Company ceases active underwriting operations, or a State Department of Insurance or other legal authority orders the Company to cease writing business in all jurisdictions; or
    3. Company has:
        a. become insolvent;
        b. been placed under supervision (voluntarily or involuntarily);
        c. been placed into liquidation or receivership; or
        d. had instituted against it proceedings for the appointment of a supervisor, receiver, liquidator, rehabilitator, conservator or trustee in bankruptcy, or other party known by whatever name, to take possession of its assets or control of its operations; or
    4. The Company's AM Best's insurer financial strength rating becomes less than A-; or
    5. The Company breaches any term of this agreement, or any of the policies referenced herein.

12. Assignment

The benefits provided under this Policy shall not be assigned, transferred, or encumbered without the written consent of the Company and, to the extent permitted by law, shall be exempt from attachment and otherwise free from claims of creditors of the Insured Person.

13. Entire Contract

The entire contract consists of this Policy, issued to the Policyholder, and any papers made a part of it, including, if any, riders and the Policyholder's application.

An Insured Person is entitled to examine a copy of the Policy during regular office hours at the Company's place of business.

14. Amendment and Alteration of the Contract

This Policy may be amended or changed only by a written agreement between the Policyholder and an authorized officer of the Company.

The Company reserves the right to provide payment of other benefits not specifically enumerated herein which includes, but is not limited to, professional and other case management fees and costs as it deems appropriate in its sole discretion. Any such payments shall not reduce any benefit payable hereunder.

15. Non-waiver of Policy Provisions

Failure of the Company to insist on compliance with any provision of this Policy at any time under any set of circumstances will not operate with respect to any other time or as to any other occurrence whether or not the circumstances are the same to:

a. waive or modify such provision; or
b. in any way render it unenforceable.

16. Non-participating Policy

This Policy is non-participating and does not share in the profits of the Company.

17. Effects of Actions of the Policyholder

In all matters regarding this Policy, except with respect to any claim filed under the Policy, the Policyholder or its authorized representative acts for the Insured Persons. Each agreement made by the Company with the Policyholder or its authorized representative will be binding on all parties, including Insured Persons and Participating Schools. Each notice given to the Policyholder by the Company will be deemed to have been given to all parties, including Insured Persons and Participating Schools.

18. Information Required

The Policyholder shall furnish to the Company, or shall use its best efforts to cause a Participating School to furnish, all information which the Company may reasonably require with regard to matters pertaining to the insurance afforded by the Policy. All documents, books, and records which may have a bearing on the insurance or premiums under the Policy shall be open for inspection by the Company or its authorized representatives during the term of the Policy and during the pendency of any claim hereunder.

19. Headings

Any section or other heading contained in this Policy is for reference purposes and convenience only and shall not affect, in any way, the meaning and interpretation of this Policy.

3300 Mutual of Omaha Plaza
Omaha, NE 68175

COMPLAINT NOTICE

Questions regarding your policy or coverage should be directed to:

Mutual of Omaha Insurance Company
Special Risk Claims
800-524-2324

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at *www.in.gov/idoi*

CLAIM REVIEW AND APPEAL PROCEDURES

For the accident medical expense policy under which you are insured, this provision is effective the later of:

(a) the effective date of the Policy; or
(b) the date required by Federal law.

Definitions
Capitalized terms have the same meaning as shown in the Policy.

For the purposes of this provision the following term has the following meaning:

Adverse Benefit Determination means a denial, reduction or termination of, or a failure to provide or to make payment (in whole or in part) for a benefit, including any such denial, reduction, termination of, or failure to provide or make payment (in whole or in part) that is based upon the Insured Person's ineligibility for insurance under the Policy.

Claim Review Procedures
Once We receive information necessary to evaluate the claim, We will make a decision within the time periods set forth below. Please refer to the Payment of Claims provision of the Policy.

In the event an extension is necessary due to matters beyond Our control, We will notify the person submitting the claim of the extension and the circumstances requiring the extension. Extensions are limited as set forth below.

If an extension is necessary due to failure to submit complete information, We will notify the person submitting the claim of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below.

In order for Us to continue processing the claim, the missing information must be provided to Us within the time periods set forth below.

We may contact the person submitting the claim at any time for additional details about the processing of the claim.

Claim Review Decisions

(a) Initial review: We will notify the person submitting the claim of Our claim decision within 45 days after Our receipt of the claim, unless additional information is requested as set forth below;
(b) Extension period: 30 days; and
(c) Maximum number of extensions: two.

If additional information is needed, We will notify the person submitting the claim within 30 days of Our receipt of the claim. Once Our request for additional information is received, the person submitting the claim will have 45 days to submit the additional information to Us. We will have a total of 105 days (which includes an additional 30-day extension, if necessary, due to circumstances beyond Our control) to process the claim. If We do not receive the additional information within the specified time period, We will make Our determination based on the available information.

Claim Denials
If a claim is denied or partially denied, the person submitting the claim will receive a written or electronic notice of the denial which will include:

(a) the specific reason(s) for the denial;
(b) reference to the specific Policy provisions on which the denial is based;
(c) if applicable, a description of any additional material or information necessary to complete the claim and the reason We need the material or information;
(d) a description of the appeal procedures, including the right to request an appeal within 180 days and the right to bring a civil action following the appeal process; and
(e) any other information which may be required under state or federal laws and regulations.

Opportunity To Request An Appeal

The person submitting the claim may appeal Our claim review decision in accordance with this Claim Review and Appeal Procedures provision. As part of the appeal, We will perform a full and fair review of the decision.

The request for an appeal can be written, electronically or orally submitted to Us and should include any additional information that the person submitting the claim believes may have been omitted from Our review that should be considered by Us.

The request for an appeal should include:

(a) the name of the person for whom the claim has been submitted;
(b) the name of the person filing the appeal;
(c) the policy number; and
(d) the nature of the appeal.

We will establish and maintain procedures for hearing, researching, recording and resolving any appeal. The notification of Our claim review decision will include instructions on how and where to submit an appeal.

The person submitting the claim will:

(a) have 180 days from receipt of notification to submit a request for an appeal;
(b) be provided the opportunity to submit written comments, documents, records and other information relating to the claim; and
(c) be provided, upon request and free of charge, reasonable access to and copies of documents, records and other information relevant to the claim.

In reviewing the appeal We will consider all comments, documents, records and other information submitted by the person submitting the claim relating to the claim, without regard to whether such information was submitted or considered in the claim decision.

Request for an appeal authorizes Us, or anyone designated by Us, to review records relevant to the claim.

Our Response To An Appeal

Once We receive a request for an appeal, We will respond within 45 days, unless additional information is requested. If additional information is requested, the following extensions apply:

(a) extension period: 45 days; and
(b) maximum number of extensions: one.

We will have a total of 90 days to process the appeal.

When We make Our decision, the person submitting the claim will be provided with:

(a) information regarding Our decision; and
(b) information regarding other internal or external appeal or dispute resolution alternatives, if available, including any required state mandated appeal rights.

Agenda Item A7
CSURMA AIME Committee
Meeting Date: January 21, 2025

RETAINED FUNDS ANALYSIS AT JUNE 30, 2024

ISSUE: The AIME Committee adopted the Goal for Retained Funds policy and procedure to assure the long-term financial strength of the AIME risk pool, which includes an element of self-insurance. The Estimated Fund Balance exhibit as well as the Goal for Retained Funds analysis report assist the Committee in its review of funding goals, assess possible impacts on future rates, and determine whether a dividend may be payable from reserve funds or if an assessment to fund deficits may be necessary. The Committee will receive a summary calculation of the surplus funds (dividend) and be asked to discuss at today's meeting.

RECOMMENDATION: The Committee is asked to review the summary calculation of the surplus fund (dividend) and discuss at today's meeting.

FISCAL IMPACT: None.

BACKGROUND: To assure the long-term financial strength of the Campus Risk Pool Programs, and in recognition of the high degree of uncertainty in actuarial estimates due to the possibility of occasional catastrophic claims, or inconsistent or inaccurate case reserving, the Goal for Retained Funds was established to guide the AIME Committee in making decisions regarding funding and dividend distribution.

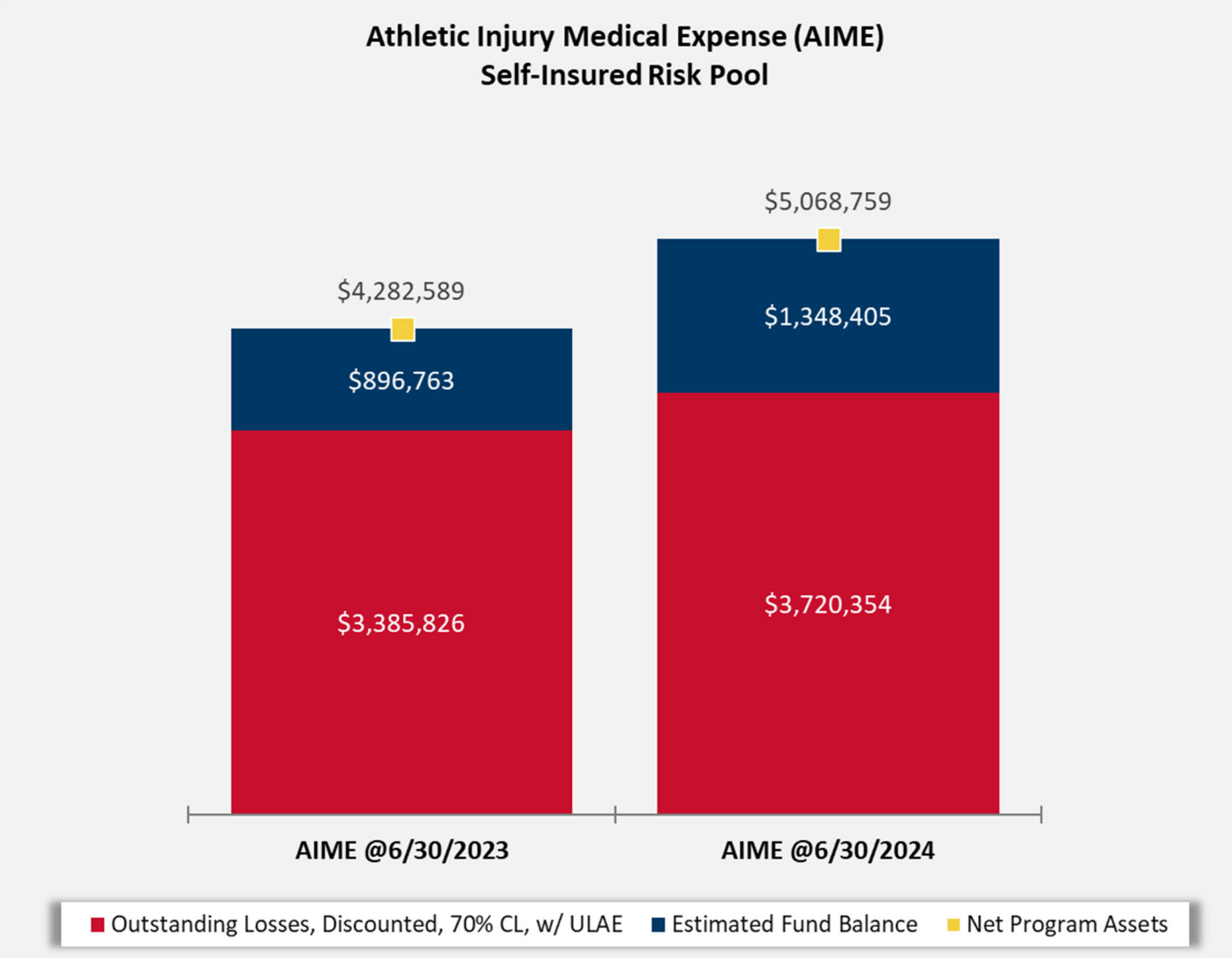
Under the authority delegated by the Executive Committee, the AIME Committee may declare dividends or assessments in accordance with CSURMA's policies and procedures.

PUBLICATION: None.

ATTACHMENT(S):

a. Estimated Fund Balance Exhibit
b. Goal for Retained Funds Analysis Report
c. Excess Surplus – Dividend Summary - HANDOUT

Estimated Fund Balance Exhibit



AIME Risk Pool
Goal for Retained Funds Analysis - Pooled Layer Funding @ $90,000
@ June 30, 2024

Analysis Factors	Current Analysis	Change	Prior Analysis
Contributions for FY 24/25	5,030,764	No Change	5,030,764
Assets at 6/30/24 #1	5,068,759	Up From	4,282,589
Maximum Retention Per Occurrence	90,000	No Change	90,000
Outstanding Liabilities at 6/30/23 (Expected, Undiscounted) #2	3,422,383	Up From	3,219,095
Outstanding Liabilities at 6/30/23 (70%, Discounted) #2	3,720,354	Up From	3,385,826
Retained Funds Above Expected Confidence Level, Undiscounted	1,646,376	Up From	1,063,494
Retained Funds Above 70% Confidence Level, Discounted	1,348,405	Up From	896,763

#1 - Assets are reduced by accounts payable, unearned revenue, costs above budgeted, and if applicable, SELF assessment.

#2 - Outstanding Liabilities are net of member deductibles, and include IBNR and ULAE.

Ratio	Target	Indicated Minimum Equity	Projected Ratio
1. Contribution to Retained Funds	< 6:1	838,461	99%
2. Retained Funds to Retention	> 5:1	450,000	**56**
3. Outstanding Liabilities to Retained Funds	≤ 5:1	684,477	68%

Dividend	Ratios
Retained Funds Above 70% Confidence Level, Discounted	1,348,405
Indicated Minimum Retained Funds (largest ratio amount)	838,461
Maximum Dividend Available	**509,944**
Recommended Dividend 50%:	**254,972**

FY 24/25 Pool Funding

Confidence levels	Risk Factor	Pooled Layer Funding *#3*	Surplus
Expected	1.000	4,112,195	-
70%	1.067	4,387,712	275,517

#3 - The Pooled Layer Funding is discounted.

Agenda Item A8
CSURMA AIME Committee
Meeting Date: January 21, 2025

AVAILITY MEDICAL DATABASE DEMONSTRATION

ISSUE: Keyonda Kendall, Sacramento State Insurance Specialist, will provide a demonstration of the Availity database, used at Sacramento State in assisting with eligibility, collection of explanation of benefits (EOB), etc. when filing claims. In addition, Keyonda will explain additional tools to assist in the paying of claims timely.

RECOMMENDATION: No action requested. This item is for information only.

FISCAL IMPACT: None.

BACKGROUND: One of the most common issues members have is collecting an EOB, required from the athlete's medical provider to pay claims. Availity offers solutions and expert database to assist a member with the ability to pay athletic claims timely.

PUBLICATION: None.

ATTACHMENTS: None.

Agenda Item A9
CSURMA AIME Committee
Meeting Date: January 21, 2025

CSURMA QUARTERLY REPORT ENDING SEPTEMBER 30, 2024

ISSUE: The CSURMA Quarterly Report Ending September 30, 2024, is attached for information purposes. This report was reviewed at the Committee's last meeting and the report ending December 31, 2024 is not yet available.

RECOMMENDATION: It is recommended the Committee review the quarterly report as presented at today's meeting.

FISCAL IMPACT: None.

BACKGROUND: Accounting records are managed by the CSU Office of the Chancellor. Periodic statements and prepared by the accountants to express the financial status of CSURMA's coverage programs.

PUBLICATION: None.

ATTACHMENT(S):

a. CSURMA Quarterly Report Ending September 30, 2024

California State University Risk Management Authority

Statement of Net Position - Campus Programs

As of 9/30/2024

(Unaudited)

	Liability	Workers' Compensation	IDL/NDI/UI	Property	AIME	Auto Liability	Total Campus Programs
Assets:							
Current assets:							
Cash and Investments	$ 22,261,923	(412,680)	19,531,795	11,756,222	4,958,987	706,908	58,803,155
Accounts receivable	6,820,649	1,328,251	—	367,802	—	—	8,516,703
Reinsurance receivable	—	41,552	—	—	—	—	41,552
Prepaid insurance	—	—	—	—	—	—	—
Prepaid expense	—	2,781,354	—	—	800,133	—	3,581,487
Noncurrent assets:							
Other long-term investments	18,873,894	36,488,246	4,384,389	1,751,383	3,478,911	—	64,976,823
Capital assets, net	1,702,224	—	—	—	—	—	1,702,224
Total assets:	**$ 49,658,690**	**40,226,723**	**23,916,184**	**13,875,408**	**9,238,031**	**706,908**	**137,621,943**
Liabilities:							
Current liabilities:							
Accounts payable	$ 326,873	8,426,340	5,746,989	13,972	380,495	—	14,894,670
Unearned revenues	—	—	—	—	—	—	—
Interest Payable	11,833	—	—	—	—	—	11,833
SBITA liabilities - current portion	902,601	—	—	—	—	—	902,601
Reported claims, current	5,500,591	2,182,120	—	—	41,374	—	7,724,085
Claims incurred but not reported, current	9,642,380	521,211	—	—	1,118,227	—	11,281,818
Noncurrent liabilities:							
SBITA liabilities - net of current portion	155,440	—	—	—	—	—	155,440
Reported claims, noncurrent	10,733,550	4,258,069	—	—	80,736	—	15,072,355
Claims incurred but not reported, noncurrent	18,815,612	1,017,064	—	—	2,182,046	—	22,014,722
Total liabilities:	**46,088,881**	**16,404,804**	**5,746,989**	**13,972**	**3,802,878**	**—**	**72,057,524**
Fund balance	3,569,809	23,821,919	18,169,195	13,861,435	5,435,153	706,908	65,564,419
Total liabilities and fund balance	**$ 49,658,690**	**40,226,723**	**23,916,184**	**13,875,408**	**9,238,031**	**706,908**	**137,621,943**

Agenda Item A10
CSURMA AIME Committee
Meeting Date: January 21, 2025

CSURMA ATHLETES NEWSLETTER

ISSUE: The Committee will receive a report and be asked to discuss, the draft January 2025 CSURMA Athletes Newsletter.

RECOMMENDATION: It is recommended the Committee review and discuss the draft January 2025 Athletes Newsletter.

FISCAL IMPACT: None.

BACKGROUND: The purpose of the Newsletter is to communicate the best policy and procedures, provide athletic news, reports and events to the CSURMA athlete members.

PUBLICATION: None.

ATTACHMENT(S):

a. CSURMA Athletes Newsletter – January 2025 (Handout)

Agenda Item A11
CSURMA AIME Committee
Meeting Date: January 21, 2025

CSURMA AIME COMMITTEE MEMBER AND STAFF CONTACT LISTS

ISSUE: Attached for the Committee's review is the AIME Committee contact list.

RECOMMENDATION: It is recommended that the Committee review the contact information for accuracy and report any changes or corrections to Staff.

FISCAL IMPACT: None.

BACKGROUND: An accurate and current list facilitates better communication among the Committee and with Staff.

PUBLICATION: None.

ATTACHMENT(S):

a. AIME Committee and Staff Contact Lists

CSURMA AIME COMMITTEE MEMBERS

As of January 2025

First Name	Last Name	Title	Organization	Street Address	Email	Phone/Cell	Term of Office Expires
Kyle	Burnett	Assistant AD, Sports Medicine (Men's BB)	CSU Fullerton	800 N. State College Blvd. Fullerton, CA 92831	kyburnett@fullerton.edu	Tel: 657-278-2858 Cell: 530-513-2944	07/01/26
Kelli	Eberlein	Assistant AD for Sports Medicine	CSU Fresno	1620 E Bulldog Lane Fresno, CA 93740	keberlein@csufresno.edu	Tel: 559-278-4170 Cell: 559-709-2534	07/01/26
Keyonda	Kendall	Student Health Athlete Care Analyst (SHACA)	CSU Sacramento	6000 J Street Sacramento, CA 95819-6045	keyonda.kendall@csus.edu	Tel: 916-278-4098 Cell:	07/01/25
Jennifer	Lupo-Northrup	Associate AD for Sports Medicine	CSU Los Angeles	5151 State University Dr., PE 64 Los Angeles, CA 90032	jlupo-northrup@cslanet.calstatela.edu	Tel: 323-343-3097 Cell: 626-419-4261	07/01/26
Kristal	Slover	Associate AD for Sports Medicine	CPSU, San Luis Obispo	1 Grand Ave San Luis Obispo, CA 93407	kemig@calpoly.edu	Tel: 805-756-6065 Cell: 805-801-5177	07/01/26
Jarrod	Spanjer	Associate AD for Student-Athlete Health & Wellness	CSU Long Beach	1250 Bellflower Blvd Long Beach, CA 90840	jarrod.spanjer@csulb.edu	Tel: 562-985-7154 Cell: 562-480-8699	07/01/25
Tina	Tubbs	Associate AD/Health, Wellness & Performance	CSU Sacramento	6000 J Street Sacramento, CA 95819-6045	tubbs@csus.edu	Tel: 916-278-4424 Cell: 805-252-1588	07/01/25
Michael	Thorpe	Executive Dirof Rsik Management & Health & Safety	CSU Chico	400 West First St Chico, CA 95929-0130	methorpe@csuchico.edu	Tel: 530-898-6588 Cell: 530-519-5661	N/A
Susan	Vollmerhausen	Senior Associate Athletics Director	CSU Bakersfield	9001 Stockdale Hwy, 8 GYM Bakersfield, CA 93311	svollmerhausen@csub.edu	Tel: 661-654-2830 Cell: 702-575-9456	07/01/25
Michael	Beatty	Execu. Director, Risk & Safety Services	San Francisco State	1600 Holloway Avenue San Francisco, CA 94132	mbeatty@sfsu.edu	Tel: 415-338-1124 Cell: 415-509-8559	N/A

AIME Advisory Committee Staff Members

As of January 2025

Organization	First Name	Last Name	Title	Street Address	Phone/Fax/Email
CSU Office of the Chancellor	Robert	Eaton	Assistant Vice Chancellor Financing, Treasury, & Risk Management	401 Golden Shore, 5th Floor Long Beach, CA 90802	Tel: 562-951-4570 Fax: 562-951-4859 Email: reaton@calstate.edu
CSU Office of the Chancellor	Zachary	Gifford	Senior Director, Systemwide Risk Management	401 Golden Shore, 5th Floor Long Beach, CA 90802	Tel: 562-951-4568 Fax: 562-951-4859 Email: zgifford@calstate.edu
CSU Office of the Chancellor	Jody	Van Leuven	Director, Systemwide Risk Management	401 Golden Shore, 5th Floor Long Beach, CA 90802	Tel: 562-951-4574 Fax: 562-951-4859 Email: jvanleuven@calstate.edu
CSU Office of the Chancellor	Leona	Ching	Administrative Analyst, Systemwide Risk Management	401 Golden Shore, 5th Floor Long Beach, CA 90802	Tel: 562-951-4575 Fax: 562-951-4859 Email: lching@calstate.edu
Alliant Insurance Services	Daniel	Howell	Program Director	560 Mission Street, 6th Floor San Francisco, CA 94105	Tel: 415-403-1426 Fax: 415-874-4810 Email: dhowell@alliant.com
Alliant Insurance Services	Amy	Lightner	Program Administrator	560 Mission Street, 6th Floor San Francisco, CA 94105	Tel: 415-403-1457 Fax: 415-874-4810 Cell: 415-660-0992 Email: amy.lighter@alliant.com
Alliant Insurance Services	Mimi	Long	Program Administrator	560 Mission Street, 6th Floor San Francisco, CA 94105	Tel: 415-403-1423 Fax: 415-874-4810 Cell: 415-609-5166 Email: mlong@alliant.com
Alliant Insurance Services	Stacey	Weeks	Program Administrator	560 Mission Street, 6th Floor San Francisco, CA 94105	Tel: 415-403-1448 Cell: 415-215-4055 Fax: 415-874-4810 Email: sweeks@alliant.com
Alliant Insurance Services	Van	Rin	Program Administrator	560 Mission Street, 6th Floor San Francisco, CA 94105	Tel: 415-403-1408 Fax: 415-874-4810 Email: vrin@alliant.com
Health Special Risk (HSR)	Cathy	Ray	Claims Administrator	8400 Belleview Dr., Ste 150 Plano, TX 75024	Tel: 972-512-5700 Email: cathyray@hsri.com
Health Special Risk (HSR)	Brandon	Schall	Claims Administrator	8400 Belleview Dr., Ste 150 Plano, TX 75024	Tel: 972-863-0390 Cell: 260-446-2711 Email: bschall@hsri.com