CERTIFICATE OF COVERAGE

Policy Form GA-2200 Ed.11-16

Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA

GROUP STUDENT BLANKET ACCIDENT INSURANCE

NON-RENEWABLE- THIS IS A LIMITED BENEFIT POLICY

2023-2024 Livingstone College – Mandatory Accident

EXCESS INSURANCE: THIS POLICY IS NOT INTENDED TO BE ISSUED WHERE OTHER MEDICAL INSURANCE EXISTS. IF OTHER MEDICAL INSURANCE DOES EXIST AT THE TIME OF THE CLAIM, THEN THE AMOUNTS OF BENEFIT PAYABLE BY SUCH OTHER MEDICAL INSURANCE WILL BECOME THE DEDUCTIBLE AMOUNT OF THIS POLICY IF SUCH BENEFITS EXCEED THE DEDUCTIBLE AMOUNT SHOWN IN THE SCHEDULE OF BENEFITS.

IT IS NOT THE INTENT OF THE POLICY TO PROVIDE BENEFITS FOR AN EXISTING MEDICAL PROBLEM. A re-injury will not be covered if the Insured has received treatment within a period of 180 days prior to the Effective date of the Policy.

POLICY EFFECTIVE DATE: 08-07-2023 at 12:01 a.m.
POLICY EXPIRATION DATE: 07-31-2024 at 11:59 p.m.

POLICY CONTENTS

IN FORCE COVERAGE

INTERCOLLEGIATE SPORTS COVERAGE

CLASSES OF ELIGIBLE PERSONS INSURED

1. Students athletes participating in covered intercollegiate sports; and
2. Student coaches, managers and trainers.

INTERCOLLEGIATE SPORTS COVERAGE - Coverage is in force for each Insured who belongs to one of the Classes of Eligible Persons Insured and for whom the premium has been paid as set forth in this Policy:

a) while practicing for or competing in intercollegiate sports which are exclusively sponsored by the Policyholder, as a representative of the School, and while under the direct and immediate supervision of an employee of the Policyholder; and
b) while traveling directly to or from such practice, participation or competition in a vehicle designated by the Policyholder while under the supervision of an employee of the Policyholder.

Note: Intercollegiate sports covered under the Policy include: Basketball, Bowling, Cheerleading, Cross Country, Football(Fall and Spring), Golf, Softball, Tennis, Track and Field, and Volleyball.

SCHOOL-TIME COVERAGE

CLASSES OF ELIGIBLE PERSONS INSURED

1. All students attending College

SCHOOL-TIME COVERAGE - Coverage is in force for each Insured, who belongs to one of the Classes of Eligible Persons Insured, for whom the School-Time Coverage premium has been paid as set forth in this Policy.

a) while on the School premises during the hours and on the days School in regular session, and
b while traveling directly to or from the Insured's residence and School for regular School sessions, or for any School-Sponsored and Supervised activity in School-provided transportation

BENEFITS FOR MEDICAL EXPENSES

When injury covered by this Policy results in treatment by a Licensed Physician within 90 days from the date of Accident, the Company shall pay the Usual and Customary Charges (U&C) incurred for necessary Covered Services, subject to all terms, conditions, limitations and exclusions of this Policy. Benefits shall be payable for eligible Expenses Incurred within two years from the date of Injury up to **Maximum Benefit of $5,000 per Injury.** Benefits shall be paid first by any other valid and collectible insurance including ERISA or self-funded group policy.

SCHEDULE OF COVERED SERVICES (unless otherwise stated all amounts are per Injury)

1. Inpatient Benefits
- a) Hospital Room and Board .....U&C
- b) Intensive Care (in lieu of 1.a.) .....U&C
- c) Hospital Miscellaneous Services .....U&C
  (all other hospital charges except room and board or intensive care)
- d) Physician's Non-Surgical Visits (does not include physiotherapy).....U&C
- e) Physiotherapy (includes office visits).....U&C
- f) X-rays and Radiology Services (includes charges for reading).....U&C
- g) Registered Nurse.....U&C

2. Outpatient Surgery Benefits
- a) Day Surgery.....U&C
  (facility charge - includes room supplies and all other expenses for outpatient surgery)

3. Other Outpatient Benefits
- a) Hospital Emergency Room Charges.....U&C
- b) X-ray Services (includes charges for reading).....U&C
- c) Diagnostic Imaging (includes CT scans, MRI and bone scans.....U&C
  and charges for reading)
- d) Physician's Non-Surgical Visits (does not include physiotherapy).....U&C
- e) Physiotherapy (includes office visits).....U&C
- f) Orthopedic Appliances (when prescribed by a physician for healing) .....U&C
- g) Durable Medical Equipment.....U&C
- g) Prescription Drugs .....U&C
- h) Ambulance Services (air or ground).....U&C
- i) Laboratory Services (includes charges for reading) .....U&C
- j) Eyeglasses, Contact Lenses and Hearing Aids .....U&C
  (replacement only when medical treatment is required for covered injury)
- k) Shots and Injections (within 24 hours of Injury) .....U&C

4. Other Physician Services
- a) Dental Treatment (in lieu of all other medical benefits; includes.....U&C
  x-rays; for repair or replacement of sound and natural teeth)
- b) Physician Surgical Care (inpatient or outpatient) .....U&C
- c) Assistant Surgeon (inpatient or outpatient) .....U&C
- d) Anesthesia Services (inpatient or outpatient) .....U&C
- e) Consultant Physician (when referred by attending physician).....U&C

5. Motor Vehicle Injury.....Same as any Injury

EXCLUSIONS

This Policy does not provide benefits for expenses resulting from:

1. Any sickness, disease, infection (unless caused by an open cut or wound), including but not limited to: aggravation of a congenital condition, blisters, headaches, hernia of any kind, mental or physical infirmity, Osgood-Schlatter disease, osteochondritis, osteochondritis dissecans, osteomyelitis, spondylolysis, slipped femoral capital epiphysis, orthodontics, injuries involving bone cysts, dental implants.
2. Services and supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer, or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
3. Any Injury involving a two or three-wheeled motor vehicle or snowmobile or any motorized or engine driven vehicle not designed primarily for use on public streets and highways, unless the insured is participating in an activity sponsored by the Policyholder.
4. Air travel or the use of any device or equipment for aerial navigation, EXCEPT as a fare-paying passenger on a regularly scheduled commercial airline.
5. Intentionally self-inflicted Injuries; Injuries sustained while fighting or brawling, or violating or attempting to violate any existing city, state, or federal law; Injuries resulting from use of alcohol, drugs or narcotics, unless administered on the advice of physician.
6. Services provided normally without charge by any person employed or retained by the Policyholder.
7. Treatment for re-Injury, EXCEPT when the Insured is treatment free for a period of 180 days prior to the Policy Effective Date.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

When Injury covered by this Policy results in the following specific Losses within 180 days from the date of Accident, the Company shall pay the benefit amount below listed opposite to the specific Loss and shall be in addition to any other benefits payable under this Policy for such Accident. If the Insured sustains more than one Loss as a result of one Accident, the Company shall pay only one amount, the largest to which the Insured is entitled. Loss of a Hand or Foot means loss by severance at or above the wrist or ankle joint. Loss of Sight must be entire and irrecoverable.

Loss of Life	$ 5,000
Loss of both Hands, both Feet or Sight of both Eyes	$ 5,000
Loss of one Hand, one Foot or Sight of one Eye	$ 5,000

DEFINITIONS

Accident - means an unexpected, external and sudden event that is independent of any other cause.

Anesthesia - Benefits are payable for the administration of anesthesia when performed by a Physician or Certified Registered Nurse Anesthetist.

Coinsurance – means the percentage of eligible expenses that are payable as Benefits by the Company. The percentage is shown in the Schedule of Covered Services.

Company - means Ameritas Life Insurance Corp.

Covered Services - means the services and supplies which are 1) Medically Necessary, 2) prescribed or performed by a Physician or Hospital for treatment of an Injury, 3) not excluded by this Policy, and 4) listed or named in this Policy's Schedule of Covered Services.

Dental Treatment – means Dentist's fees for surgery, x-rays, and other necessary dental services as a result of Injury to a Sound and Natural Tooth.

Diagnostic Imaging - means the images of the body created using other forms of radiology that does not include x-ray radiographs (films), including but not limited to: computerized axial tomography (CT); magnetic resonance imaging (MRI); radionuclide imaging (nuclear medicine); bone scans; and ultrasound (US). Benefit includes the fees for interpretation or reading of imaging results and the administration of contrast material.

Durable Medical Equipment – means medical equipment or device which can be rented, leased or purchased and which 1) is prescribed by a Physician; 2) is primarily and customarily used to serve a medical purpose; 3) can withstand repeated use; 4) generally is not useful to a person in the absence of Injury; and 5) is used exclusively by the Insured. Replacement equipment and devices are not covered. No benefits will be paid for rental charges in excess of purchase price. Durable Medical Equipment does not include non-prescription therapy devices or medical supplies; comfort and convenience items; corrective shoes; exercise and sports equipment. A written prescription must accompany the claim when submitted.

Expense Incurred – means the charge made for a service, supply, or treatment that is a Covered Service under this Policy. The expense is considered to be incurred on the date the service or treatment is given or the supply is received.

Hospital - means an institution which 1) is licensed by the state (if required) or other laws of jurisdiction; 2) is operated for the medical care and treatment of injured persons on an inpatient basis; 3) provides 24-hour nursing services or supervised by a graduate registered nurse; 4) has medical, diagnostic and treatment facilities with major surgical facilities on its premises or available to it on prearranged basis; 5) has a staff of one or more Physicians available at all times. Hospital includes payment of benefits for charges made for medical care rendered in or by a duly licensed State tax-supported institution that does not have an operating room and related equipment for the performance of surgery. It does not include payment for domiciliary or custodial care, rehabilitation, training, schooling or occupational therapy.

Injury - means an accidental bodily Injury or injuries directly caused by specific accidental contact with another body or object while the Insured is covered under this Policy. It is unrelated to any pathological, functional, or structural disorder. The Accident must result in an Injury which begins while the Insured is covered under this Policy.

Inpatient – means confinement in a Hospital for at least eighteen (18) or more consecutive hours.

Intercollegiate Sports/Club/Intramural Sports: Intercollegiate Sports means any athletic contest or competition, regulated by a national association, between accredited colleges or universities. The participants are sponsored by the Policyholder and are under the direct and immediate supervision of an employee of the Policyholder. It includes the practice or training for the competition and the travel to or from such practice or competition in a vehicle designated by the Policyholder, both while under the direct and immediate supervision of an employee of the Policyholder. **Club /Intramural Sports** means any athletic contest or competition by clubs or organizations that is not an Intercollegiate Sport and that may or may not be sponsored by the Policyholder. Club sports may or may not be under the direct and immediate supervision of an employee of the Policyholder.

Medically Necessary – means a Covered Service which is: 1) consistent with symptoms and diagnosis or treatment of Injury; 2) in accordance with standards of generally accepted medical practice; 3) not primarily for the convenience of the patient or Physician; and 4) most appropriate supply or level of service which can be safely provided.

Orthopedic Appliances – means a supportive appliance or device designed specifically for use in the correction or prevention of human deformities, defects of the skeleton, joints, or spine and which: 1) is prescribed by a Physician; 2) is primarily and customarily used to serve a medical purpose; 3) can withstand repeated use; 4) generally is not useful to a person in the absence of Injury; and 5) is used exclusively by the Insured. Replacement braces and appliances are not covered. A written prescription must accompany the claim when submitted.

Other Valid Coverage - means any plan providing benefits or services for medical or dental care or treatment, where such benefits or services are provided on a group basis by or under: group insurance; coverage provided by hospital or medical service organizations such as Blue Cross or Blue Shield or similar pre-paid medical service organizations; union welfare or trust plans including ERISA or self-funded group policies; employer or employee benefit plans or arrangements, whether on an insured or uninsured basis; Medicare as established by Title XVIII of the United States Social Security Act of 1965, as amended; HMO (health maintenance organization); or PPO (preferred provider organization); group type contracts which are not available to the general public and can be maintained only because of membership in or connection with a particular organization or group. These types of contracts include but are not limited to; associations, franchise, or blanket policies of accident, disability or health insurance.

"Other Valid Coverage" does not include a state plan under Medicaid, or any plan whereby law that plan's benefits are excess to those of any private insurance plan or other nongovernmental plan. No third-party liability coverage shall be included as Other Valid Coverage

Physician - means a doctor of medicine or osteopathy, or any other licensed health care provider that state law requires to be recognized as a Physician, other than the Insured or Insured's relative by blood or marriage, who is acting within the scope of such license.
Physiotherapy - means any form of therapeutic or manual treatment provided by a Physician, including but not limited to: physical or mechanical therapy, diathermy, ultrasonic treatment, EMS, whirlpool, heat treatments or manipulation. Includes office visit connected with the physiotherapy.
Prescription Drug – means a drug which has been determined to be safe and effective by the Food and Drug Administration and which can, under federal or state law, only be dispensed when ordered by a Physician who is duly licensed to prescribe such medication.
Residence - means the building and grounds where the Insured lives.
Sound and Natural Tooth - means the major portion of the individual tooth, formed by the human body, is present. Does not include teeth that are carious, abscessed, or defective.
Sponsored and Supervised Activity - means any activity which is exclusively sponsored by the Policyholder and which is under the direct and immediate supervision of an employee of the Policyholder.
Surgical Care – means Physician's fees for surgery. Surgical procedures are identified in the Surgery section of the Physicians' Current Procedural Terminology (CPT). Unless otherwise defined in the Schedule of Covered Services, if two or more procedures are performed through the same incision or at the same operative session, the maximum amount payable for the subsequent procedure(s) will not exceed 50% of the Usual and Customary Charges for the subsequent procedure(s).
Usual and Customary Charges (U&C) - means charges for medical services or supplies for which the Insured is legally liable and which do not exceed the average rate charged for the same or similar services or supplies in the geographic region where the services or supplies are received. Usual and Customary Charges for Covered Services - Supplies are determined by referencing the 75th percentile of the most current survey published by Fair Health Inc. for such Covered Service.
X-ray Services - Covered Services includes x-ray and radiology examination, consultation and fees for interpretation or reading of X-rays and other radiology results. Diagnostic X-rays are obtained from an x-ray machine and images are recorded on radiographs (films). This benefit does not include Diagnostic Imaging if listed as a separate benefit in the Schedule of Covered Services.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES
This Policy, including the endorsements and attached papers, if any, and the Policyholder's application constitute the entire contract of insurance. All statements made by the Policyholder shall, in the absence of fraud, be deemed representations and not warranties. No such statements will be used in defense to a claim under this Policy unless it is contained in the written application signed by, and furnished to, the Policyholder. No changes in this Policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon and attached hereto. No agent has authority to change this Policy or to waive any of its provisions.
NOTICE OF CLAIM
Written notice of claim must be given to the Company's Administrative Office within thirty (30) days after the occurrence or commencement of any loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given on behalf of the Insured or the beneficiary to the Company's Administrative Office, 333 North Main Street, Suite 300, Stillwater, MN 55082, or its authorized agent, with information sufficient to identify the Insured, shall be deemed notice to the Company.
CLAIM FORMS
The Company, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proofs covering the occurrence, the character and the extent of loss for which claim is made.
PROOFS OF LOSS
Written proof of loss must be furnished to The Company's Administrative Office, 333 North Main Street, Suite 300, Stillwater, MN 55082 within 180 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.
TIME PAYMENT OF CLAIMS
The Company shall, within 30 calendar days after receipt of a claim, if submitted electronically or paper mail by the claimant: 1) pay the claim; 2) send notice of denial of the claim; 3) send notice requesting additional information; 4) send notice that the claim was not submitted on the form required by the Company or applicable law; 5) send notice requesting other valid coverage information; 6) notice that the claim is pending for nonpayment of premium.
If the claim is denied, the notice shall include all the specific good faith reason(s) for the denial, including, without limitation, other valid coverage, lack of eligibility, or lack of coverage for the services provided. If the claim is contested or cannot be paid because proof of loss is incomplete or inadequate or not paid pending requested other valid coverage information, the notice shall include an itemization or description of all the information needed by the Company to complete and process the claim. If the claim is contested or cannot be paid because a medical necessity standard is not satisfied, the notice shall contain the specific clinical rationale for the decision. If the claim is contested or cannot be paid because of nonpayment of premium, the notice shall contain a statement advising the claimant of the nonpayment of premium. If the claim is contested or cannot be paid because the claim was not submitted on the required form, the notice shall contain the required form with instructions to complete the form.
If the claim is denied or contested in part, the Company shall pay the undisputed portion of the claim within 30 calendar days after the receipt of the claim and send the notice of the denial or contested status within 30 days after receipt of the claim.
Upon receipt of additional information requested in the notice to the claimant, the Company shall pay or deny the claim within 30 days after receiving the additional information.
If the Company requests additional information and does not receive the additional information within 90 days after the request was made, the Company shall deny the claim and send notice of the denial to the claimant. The Company shall inform the claimant in the notice that the claim will be reopened if the information previously requested is submitted to the insurer within one year after the date of the denial notice closing the claim.

If the claim for which the claimant is the health care provider or facility has not been paid or denied within 60 days after receipt of the initial claim, The Company shall send a claim status report to the Insured, unless the Company is waiting for additional information from the provider or facility. If the claim remains unresolved 30 days after the first claim status report, another claim status report must be sent to the insured and provider every 30 days while the claim remains unresolved. In the event the additional information is not received within 90 days of the request, the Company shall deny the claim and provide notice to the claimant.
If the Company fails to pay, deny or settle a clean claim in accordance with the time periods set forth in this provision, the Company shall pay interest at annual percentage rate of eighteen percent beginning on the date following the date on which the claim should have been paid. If additional information was requested by the Company, interest of the claim payment shall begin to accrue on the 31st day after the insurer received the additional information. This provision does not apply to claims for benefits that are not covered under the Policy, nor does it apply to deductibles, copays, or other amounts for which the Company is not liable. The Company is not subject to interest payments if its failure is caused in material part by: 1) the person submitting the claim, 2) by matters beyond the Company's reasonable control, or 3) if the Company has a reasonable basis to believe the claim was submitted fraudulently and notifies the claimant of the alleged fraud.

LEGAL ACTIONS

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

TIME LIMIT ON CERTAIN DEFENSES is added: After 2 years from the Policy Effective Date no misstatements can be used to void the policy or to deny a claim for Loss incurred or disability (as defined in the Policy) commencing after the expiration of such two-year period.

EXCESS PROVISION is added**:** If the Premium for the coverage provided is paid entirely by the Policyholder, and if there is Other Valid Coverage, not with the Company, providing benefits for the same Loss on a provision of service basis or on an expense incurred basis, benefits for Eligible Expenses will be paid first by such other company or service plan.

EFFECTIVE DATE AND EXPIRATION DATE

Group coverage under this Policy with respect to each Insured shall become effective on the later of the following dates:

a) 12:01 a.m. following the date the application and premium payment is received by the Company's Administrative Office or its authorized agent; or
b) the Policy Effective Date.

Coverage under this Policy with respect to each Insured will end on the earliest of the following dates:

a) 11:59 p.m. on the date on which the Insured ceases to be enrolled in the College if coverage is purchased; or
b) 11:59 p.m. on the last date of the period of coverage for which the premium was paid; or
c) 11:59 p.m. on the last date of the authorized season or activity for the Intercollegiate Sports of the current Policy period; or
d) 11:59 p.m. on the Policy Expiration Date.

PREMIUM

This coverage requires 100% participation; the premium for coverage is paid by the College.

CLAIM PROCEDURE

Notify the College immediately when an accident has occurred. Secure a claim form from the Servicing Agent website, **www.livingstonecollegestudentinsurance.com**. Fill in the necessary information, attach all itemized doctor and hospital bills, and other insurance explanation of benefits and send to: Student Assurance Services, Inc.
P.O. Box 196, Stillwater, MN 55082

Note: Proof of loss must be submitted to the address above within 180 days from the date of accident, or a reasonable time thereafter not to exceed one year.

To check the status of your filed claim, questions regarding receipt of premium or verification of coverage may be answered by calling the Claims Office from 8:00 to 4:30 p.m. (Central Time), Monday – Friday or send an email.

Associated Insurance Plans International, Inc.
609 N Pine Street, Suite 202
Burlington, WI 53105
Phone: (800) 452-5772
Email: **office@aipstudentinsurance.com**
website: **www.livingstonecollegestudentinsurance.com**

Keep this certificate as your summary of coverage – no individual policy will be issued. A master policy is issued to the Policyholder. The master policy contains the contract provisions and shall prevail in the event of any conflict between this certificate and the master policy.

Privacy Notice: You may obtain a copy of the Privacy Notice from the Policyholder or by contacting Student Assurance Services, Inc.