POLICY SCHEDULE OF BENEFITS

POLICY NO.: SB21CCNC-P-054219

POLICYHOLDER/SPONSORING ORGANIZATION INFORMATION:

North Carolina High School Athletic Association
PO Box 3216
Chapel Hill, NC 27516

Effective Date: August 1, 2021 **Expiration Date:** August 1, 2022

ELIGIBILITY:

All student athletes, student managers, student trainers, student cheerleaders, school health care professionals and students participating in interscholastic competition and all school personnel supervising NCHSAA student services programs.

Coverage is provided for students and/or staff participating in interscholastic competition, governed by the regulations of the state high school athletic/activities authority, including school-supervised practice, tryouts, game related activities.

SCOPE OF COVERAGE:

Class	Insured Risk	Benefits
All	Sponsored Activity (IRCATCUST001)	Medical Expense (AMECAT001) AD &Specific Loss Benefit (ADSLCAT4PLG001)

AGGREGATE LIMIT OF LIABILITY:	$5,000,000.00
DEDUCTIBLE - (Reducing):	$25,000.00
DEDUCTIBLE ESTABLISHMENT PERIOD:	24 months

BENEFITS:

Medical Expense Benefit-Full Excess:

Benefit Percentage	100%
Maximum Benefit Period	the sooner of the Date of Recovery or 10 Years from accident date
Maximum Benefit Amount	$5,000,000.00
Maximum for Medically Necessary Hospital Inpatient Services and Supplies	Included in Medical Maximum
Maximum for confinement in an Extended Care Facility per Calendar Year	$365,000.00
Daily Room and Board Limit	
Private or Semi Private Room	Average Semi Private rate of Hospital in which confined
Intensive Care	Allowable Expense
Combined Home Health Care and Custodial Care Maximum Benefit per Calendar Year	$100,000.00
Custodial Care Maximum Benefit per Calendar Year subject to the Combined Home Health Care and Custodial Care Maximum Benefit per Calendar Year	$0.00

Home Health Care Maximum Benefit per Calendar Year subject to the Combined Home Health Care and Custodial Care Maximum Benefit per Calendar Year	$100,000.00
Treatment of Mental or Nervous Disorders	
Doctor Fees –	
Amount per Visit	$90.00
Visits per Day	1
Number of Visits per Calendar Year	50
Inpatient Hospital	Up To 45 Days
Maximum Spinal Manipulation Benefit	
Maximum amount per Calendar Year	$1,000.00
Maximum Outpatient Physical Therapy Benefit	
Maximum amount per Calendar Year	$50,000.00
Maximum Prosthetic Limitation	
Benefit Amount payable during the first two (2) Years after covered accident	$100,000.00
Benefit Amount payable for the remainder of the benefit period immediately thereafter	$100,000.00
If amputation of the leg is above the knee	$200,000.00
Maximum Benefit Amount	$500,000.00
If amputation of the leg is above the knee	$750,000.00

Accidental Death and Specific Loss and Paralysis Benefit

Principal Sum	$10,000.00
Loss Establishment Period	365 Days
Quadriplegia is total Paralysis of four limbs	100% of Principal Sum
Paraplegia is total Paralysis of both lower limbs	100% of Principal Sum
Hemiplegia is total Paralysis of an upper and lower limb	100% of Principal Sum
Uniplegia is total Paralysis of one upper limb or one lower limb	50% of Principal Sum
Loss Establishment Period	60 Days and continuing for at least (1) year from the date of loss of function

The following riders are attached to and made a part of this policy:

Exclusions and Limitations Amendment Rider	0PC7M
Guaranty Association Act Notice	M20111_1013

090221:bdt

Mutual of Omaha

3300 Mutual of Omaha Plaza
Omaha, NE 68175

This policy is a legal contract between the Policyholder shown on the Schedule and Us. It is issued in consideration of the payment of the required premium. We agree to pay benefits, subject to the terms, conditions, and limitations of this policy.

This policy is issued in and will be interpreted by the laws of the State of North Carolina, without giving effect to the principles of conflicts of law of that State or any other state. Any part of this policy which is in conflict with the laws of the State of North Carolina is changed to conform to the minimum requirements of that State's laws.

THIS POLICY INCLUDES AN EXCLUSION FOR PRE EXISTING CONDITIONS

POLICY TERM – RENEWAL

This policy goes into effect on the Policy Date shown on the Schedule. The initial term ends on August 1, 2022. This policy may be renewed for additional terms with Our written consent. Each term beings and ends at 12:01 a.m., Standard Time, at the main office of the Policyholder.

THIS IS A BLANKET LIMITED ACCIDENT POLICY.

READ IT CAREFULLY.

BENEFITS ARE NOT PAYABLE FOR LOSS DUE TO SICKNESS.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Us.

James T. Blackledge

Chief Executive Officer

Daya Venkat

Corporate Secretary

FOR RESIDENTS OF NORTH CAROLINA

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL:

1. CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT; AND

2. WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES.

VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

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INSURED RISKS

Unless otherwise stated on the Schedule, We will pay benefits for a loss only once, even if coverage was provided under more than one insured risk.

SPONOSRED AND SUPERVISED ACTIVITY COVERAGE (IRCATCUST001)

We will pay the benefits in this policy for an Insured while:

- participating in a Sponsored and Supervised Activity as shown on the Schedule;
- traveling in transportation:
    - proceeding directly to and from and without interruption between approved locations authorized by the Policyholder.

ELIGIBILITY FOR BENEFITS

ELIGIBILITY

Persons who are eligible to be an Insured under this policy are described on the Schedule. This includes persons who may become eligible while this policy is in force.

WHEN INSURANCE BEGINS

Insurance for an Insured begins on the later of:

- the Policy Effective Date or
- the day the Insured becomes eligible under the terms of this policy.

CHANGE IN COVERAGE

Any change in the Insured's coverage because of change of class as shown on the Schedule will become effective on the date of the change.

WHEN INSURANCE ENDS

Insurance for an Insured will end on the earliest of the date:

- the Insured is no longer eligible;
- the Insured enters full time active duty in any Armed Forces;
- any premium for the Insured is due and unpaid, subject to the Grace Period provision; or
- this policy is terminated.

Termination of insurance will not affect a claim incurred while coverage was in effect.

BENEFITS

We pay benefits under this policy subject to the TERMS OF BENEFITS section after the Insured satisfies the Deductible. Benefits may be adjusted for factors that include, but are not limited to, discounts, write-offs, and negotiated fees.

MEDICAL EXPENSE (AMECAT001)

We will pay the following Medical Expenses incurred as a result of an Accident. Benefits are subject to the Deductible, Benefit Percentage, Maximum Benefit Amount, Benefit Period, and any applicable sub-limit amounts shown on the Schedule.

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 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:
    a. pre-admission testing if Hospital confinement occurs within seven days of the testing;
    b. emergency room treatment. Treatment must be received within 72 hours of the Accident;
    c. emergency room physician; or
    d. use of surgical facilities;
5. surgical charges for the primary performance of a surgical procedure by a Physician subject to the following:
    a. if bilateral or multiple surgical procedures are performed by one Physician, We will pay the Medical Expenses for the primary procedure;
    b. for each procedure that is not the primary procedure performed through the same incision as the primary procedure, We will pay 50% of the amount otherwise payable if the additional procedure were the primary procedure;
    c. if multiple surgical procedures are performed during the same operating session, reimbursement will be based upon the following: 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;
    d. 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;
    e. 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
    f. if two or more Physicians perform a procedure that is normally performed by one Physician, We will only pay the Medical Expenses for the primary Physician;
6. surgical charges for assistant surgeon duties will be reimbursed at 25% of the Allowable Expense for surgery codes that have been assigned an assistant surgery indicator by the Centers for Medicare & Medicaid Services;
7. charges for anesthesia and its administration for surgery;
8. charges for a second surgical opinion or consultation by a Physician;
9. Physician's charges for other than pre- or post-operative care for in-Hospital visits or office visits;
10. charges for Laboratory Tests and diagnostic imaging including X-Ray, or MRI, or CAT Scan and the Physician's charges for reading or interpreting the results;
11. charges for Spinal Manipulation;
12. charges for Durable Medical Equipment;
13. charges for physiotherapy which includes:
    a. adjustment;
    b. diathermy;
    c. heat treatment;
    d. manipulation;
    e. microtherm;
    f. ultrasonic;
14. charges for Ambulance Service (Surface) or and Ambulance Service (Air);
15. charges for Orthopedic Appliances;
16. charges for Prescription Drugs;
17. charges for dental treatment when Injury occurs to sound natural teeth;

18. charges for confinement in an Extended Care Facility;
19. charges for a Nurse, other than routine Hospital care, by or under the supervision of a Nurse;
20. charges for Home Health Care;
21. charges for Custodial Care services or treatment;
22. charges for prosthetic devices;
23. care and treatment of mental or nervous disorders by a Physician;
24. for medical or surgical services and other medical supplies commonly Used for therapeutic or diagnostic services, which are prescribed by a Physician;
25. charges incurred within five years from the date of the Accident for the removal of Internal Fixation mechanical devices inserted as a result of a covered Accident; and
26. other Medical Expenses as noted on the Schedule.

ACCIDENTAL DEATH AND SPECIFIC LOSS BENEFIT (ADSLCAT4PLG001)

We will pay the benefit amounts shown below, based upon the Principal Sum shown on the Schedule, for accidental death and specific loss which:

- results solely from an Injury to the Insured that occurs during a Sponsored and Supervised Activity and from no other contributory cause; and
- is sustained within the Loss Establishment Period.

If an Insured sustains more than one such loss as the result of one Accident, We will pay only the largest benefit to which the Insured is entitled. This amount will not exceed the Principal Sum that applies for the Insured.

TABLE OF BENEFITS FOR ACCIDENTAL DEATH AND SPECIFIC LOSS

Loss	*Benefit Amount*
Loss of Life	100% of Principal Sum
Loss of Both Hands	100% of Principal Sum
Loss of Both Feet	100% of Principal Sum
Loss of Entire Sight of Both Eyes	100% of Principal Sum
Loss of One Hand and One Foot	100% of Principal Sum
Loss of One Hand and Entire Sight of One Eye	100% of Principal Sum
Loss of One Foot and Entire Sight of One Eye	100% of Principal Sum
Loss of Speech and Hearing	100% of Principal Sum
Loss of Entire Sight of One Eye	50% of Principal Sum
Loss of Speech or Hearing	50% of Principal Sum
Loss of One Hand or One Foot	50% of Principal Sum
Loss of Thumb and Index Finger	25% of Principal Sum
Quadriplegia (Paralysis of Four Limbs)	100% of Principal Sum
Paraplegia (Paralysis of Both Lower Limbs)	100% of Principal Sum
Hemiplegia (Paralysis of an upper and lower limb)	100% of Principal Sum
Uniplegia (Paralysis of a limb)	50% of Principal Sum

EXCLUSIONS AND LIMITATIONS (EXCAT001-NC)

No benefits are payable for:

1. any Heart or Circulatory Malfunction;
2. Repetitive Motion Injuries or the aggravation thereof;
3. bacterial infection, except infection of and through a wound accidentally sustained;
4. loss from intentionally self-inflicted injury, suicide while sane or insane;
5. loss from commitment of or an attempt to commit a felony, or engagement in an illegal activity;
6. loss from an act of declared or undeclared war, not including acts of terrorism;
7. loss from active participation in a riot or insurrection;
8. loss from travel or flight in or descent from any aircraft, unless the Insured is a passenger for authorized group or team travel on a regularly scheduled flight on a commercial airline, or is a passenger on an aircraft chartered solely for the purpose of travel which has a valid airworthiness certificate from the jurisdiction in which operated and which is being operated by a duly licensed pilot;
9. charges which exceed the Allowable Expense;
10. charges incurred for dental work unless the Insured sustains an Injury which results in damage to his or her natural teeth;
11. charges incurred for television, telephone, water pitcher, and other personal convenience items, or expenses for other persons, except as may be specifically provided for elsewhere in this policy;
12. charges incurred for services or supplies not specifically provided for in the policy;
13. charges which would not have been made in the absence of insurance or which the Insured is not legally obligated to pay;
14. charges incurred for cosmetic procedures, unless made Medically Necessary by an Injury;
15. charges incurred for eyeglasses, contact lenses, or hearing aids or for any examination or fitting related to these devices unless made Medically Necessary by an Injury;
16. charges incurred for care, treatment, or service which is not Medically Necessary to the diagnosis or treatment of an Injury;
17. charges incurred for the professional services of a person who either lives with the Insured or is an Immediate Family Member;
18. charges incurred for Experimental or Investigational Drug or Treatment;
19. charges incurred for articles of clothing which are intended for use more than once;
20. routine medical examination and related medical services;
21. charges which are recoverable from any other insurance policy, service contract, or other arrangements of insured or self-insured group coverage;
22. services or supplies for 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;
23. charges for mental or nervous disorders, except as specifically provided herein;
24. elective treatment or surgery, health treatment or examination where no Injury is involved;
25. acts of aggression, assault or battery (only if instigated by the Insured);
26. fighting or brawling (other than an act of aggression instigated by an Insured);
27. drugs that promote fertility, treat infertility, enable sexual performance, or provide sexual enhancement;
28. injuries associated with activities or travel outside the United States unless the Injury occurred as part of an Activity held outside the United States and the treatment is not considered an Experimental or Investigational Drug or Treatment in the United States;
29. sickness, disease, bodily or mental infirmity, or medical or surgical treatment thereof, or bacterial or viral infection, regardless of how contracted. This does not exclude bacterial infection that is the natural and foreseeable result of an Injury or accidental food poisoning;
30. treatment in any Veterans Administration or federal Hospital, unless there is a legal obligation to pay;
31. Pre-existing Condition;

32. active duty service in any Armed Forces;
33. operating a motor vehicle under the influence of a Controlled Substance unless administered on the advice of a Physician and taking the prescribed dosage;
34. operating a motor vehicle while having a blood alcohol level that equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the Injury occurred;
35. services or treatment incurred to the extent they are paid or payable under any Other Insurance Plan;
36. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any Other Insurance Plan.

NONDUPLICATION OF BENEFITS

If any item of expense is payable under more than one provision of this policy, We will pay only the largest benefit to which the Insured is entitled.

TERMS OF BENEFIT PAYMENTS

We will pay the benefits specified in the BENEFITS section to all Insureds who suffer a loss within the Scope of Coverage due to Injury. We consider a claim for an expense for treatment, service, or purchase to be incurred under this policy on the date the treatment or service is provided or the purchase is made.

FULL EXCESS MEDICAL EXPENSE (TBCATFE001)

We will pay the Medical Expenses an Insured incurs that exceed amounts payable by any Other Insurance Plan, subject to the Deductible, Benefit Percentage, and Benefit Period shown on the Schedule. We will determine the amount of benefits provided by any Other Insurance Plan without reference to any coordination of benefits, non-duplication of benefits, or similar provisions. The amount of benefits provided by an Other Insurance Plan includes any amount to which the Insured is entitled whether or not a claim is made for the benefits. This policy is secondary to all Other Insurance Plans.

If an Insured is covered under a policy issued by another insurance carrier which provides substantially similar benefits and provisions and has a deductible of $25,000 or more, such policy will not be considered an Other Insurance Plan. Instead, this policy, on an excess basis over all Other Insurance Plans, will share payment of eligible benefits with the other policy by contribution based on equal shares. Under this approach, this policy will contribute an amount equal to that contributed by the other catastrophic policy until the benefits owed are paid.

The first Medical Expense must be incurred within the Loss Establishment Period stated on the Schedule.

The Maximum Benefit Amount payable and sub-limits under this policy are shown on the Schedule.

AGGREGATE LIMIT OF LIABILITY

The Aggregate Limit of Liability per Insured is shown on the Schedule. We will not be liable for any amount over this limit for any Insured for any one Accident.

CLAIM PROVISIONS

NOTICE OF CLAIM

We must receive written notice within 90 days after a loss occurs or begins, or as soon as reasonably possible. Notice can be given at Our home office or to Our authorized representative. Notice should include:

- the Policyholder's/Sponsoring Organization's name;
- the policy number; and
- the Insured's name and address.

CLAIM FORMS

When We receive the notice of the claim, We will send forms for filing proof of loss within 15 days. If We do not send the necessary forms within 15 days, written information may be given that includes the nature, date, cause, and extent of the loss for which claim is made.

PROOF OF LOSS

We must be given written proof of loss at Our home office or to Our authorized representative within 180 days after the date of the loss. If the written proof is not given within 180 days, the claim will not be invalidated or reduced if:

- it was not reasonably possible to give proof within 180 days and
- proof is given as soon as reasonably possible, but not later than one year from the date it is otherwise required, except in the absence of legal capacity.

If the claim is for a continuing loss for which this policy provides periodic payments, written proof that the loss continues must be given to Us or to Our authorized representative at the intervals We require.

Physical Examination and Autopsy

We, at Our expense, have the right to have an Insured examined, as often as it may reasonably require, whenever his or her loss is the basis of a claim.

We, at Our expense, have the right to require an autopsy of the Insured if not prohibited by law.

PAYMENT OF CLAIMS

We will pay benefits immediately after We receive acceptable proof of loss and confirm benefits are payable.

We will pay benefits for loss of life and any benefits payable to the Insured but unpaid at the Insured's death to the Insured's named beneficiary for this policy. This choice must be in writing and filed with Us, or filed with the Policyholder/ Sponsoring Organization if We have agreed in advance.

The Insured has the right to change the beneficiary. Unless this right has been given up, the Insured does not need the consent of the beneficiary to make a change.

If the Insured has not named a beneficiary or no beneficiary survives the Insured, We will pay benefits at the Insured's death as follows:

- to the Insured's surviving spouse; if none, then
- in equal shares to the Insured's surviving children; if none, then
- in equal shares to the Insured's surviving parents; if none, then
- in equal shares to the Insured's surviving brothers and sisters; if none, then
- to the Insured's estate.

If benefits are payable to a person who is not legally competent to claim or release benefits, a minor, or an estate, We may pay up to $1,000 to any relative by blood or marriage whom We find entitled to the payment. This good faith payment satisfies Our legal duty to the extent of the payment.

Assignment of Benefits

The Insured may direct that We pay benefits to a Hospital, Physician, or other provider who furnished care, diagnosis, advice, or supplies. We are not liable for any actions We take before We receive notice of the assignment. We are not responsible for the validity of any assignment of benefits.

OPPORTUNITY TO REQUEST AN APPEAL

The claimant may request an appeal, in writing, within 60 days after receiving notice of Our initial claim review decision.

The request for an appeal should include:

- the Policyholder's/Sponsoring Organization's name and the policy number or group number;
- the Insured's name and mailing address;
- the name and mailing address of the claimant filing the appeal, if different from the Insured;
- the nature of the appeal; and
- any additional information that may have been omitted from Our review or that We should consider.

By requesting an appeal, the claimant has authorized Us, or anyone We designate, to review any and all records (including, but not limited to, medical records) which We determine may be relevant to the appeal. We will review all information submitted and make Our final determination. No additional appeals are available.

Applicable state laws may contain requirements for claims review and appeal procedures. To the extent that this provision is inconsistent with any state law requirement, the requirement that is most favorable to the claimant will apply.

AUTHORITY TO INTERPRET POLICY

By purchasing this policy, the Policyholder/Sponsoring Organization grants Us the discretion and the final authority to construe and interpret this policy. This means that We have the authority to decide all questions of eligibility and all questions regarding the amount and payment of any policy benefits within the terms of this policy as We interpret it. We will pay benefits under this policy only if We decide, in Our discretion, that a person is entitled to them. In making any decision, We may rely on the accuracy and completeness of any information furnished by the Policyholder/Sponsoring Organization, an Insured, or any other third party. Our interpretation of this policy as to the amount of benefits and eligibility will be binding and conclusive on all persons.

The Policyholder/Sponsoring Organization further grants Us the authority to delegate to third parties, including, without limitation, any third party administrator with whom We have contracted to provide claims administration and other administrative services, the discretionary authority granted in this policy. The Policyholder/Sponsoring Organization expressly grants such third party the full discretionary authority granted to Us under this policy.

PREMIUM PROVISIONS

REPORTING REQUIREMENTS

The Policyholder/Sponsoring Organization or its authorized agent must report to Us any additional information required as We and the Policyholder/Sponsoring Organization agree. We must receive this report before the premium due date.

GRACE PERIOD

There is a 31-day grace period for payment of each premium due after the first premium. This means that, except for the initial premium, if premium is not paid on or before the date it is due, the premium must be paid in the 31-day period that follows. We will consider premium to be paid on the date We receive it.

Insurance will stay in force during the grace period unless the Policyholder/Sponsoring Organization has notified Us of its intention to terminate this policy.

If We have not been notified otherwise and the premium has not been paid, this policy will end on the date premium was due.

CHANGES IN RATES

We have the right to change the premium rates:

- at any time there is a change in the coverage provided or classes eligible;
- at any time there is a change in the risks We have assumed; or
- after the first 12 months insurance is in effect.

New rates based on coverage or eligibility changes will take effect on the effective date of those changes. Otherwise, We will give 45 days written notice when We change the rates. Notice will be sent to the Policyholder's/Sponsoring Organization's most recent address in Our records.

REINSTATEMENT AFTER TERMINATION

If this policy terminates due to any renewal premium be not paid within the time granted the Policyholder/Sponsoring Organization for payment, the Policyholder/Sponsoring Organization may request to reinstate it by written request. If We or any agent duly authorized by Us subsequently accept the premium without requiring an application for reinstatement, We will reinstate the policy.

If We require an application for reinstatement and issue a conditional receipt for the premium tendered, the policy will be reinstated upon approval of the application by Us or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt, unless We have previously notified the Policyholder/Sponsoring Organization in writing of its disapproval of such application.

The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement. In all other respects We and the Policyholder/Sponsoring Organization shall have the same rights thereunder as under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.

GENERAL PROVISIONS

INSURANCE CONTRACT

The insurance contract consists of:

- this policy;
- the attached Schedule; and
- any riders or endorsements.

The insurance contract may be changed (including reducing or ending benefits or increasing premium costs) any time We and the Policyholder/Sponsoring Organization both agree to a change, unless required by law. No one else has the authority to change the insurance contract. A change in the insurance contract must be:

- in writing;
- made a part of this policy; and
- signed by Our authorized representative in Our home office.

WORKERS COMPENSATION INSURANCE

This policy does not satisfy any requirement for coverage under any workers compensation law.

POLICYHOLDER/SPONSORING ORGANIZATION RECORDS

The Policyholder/Sponsoring Organization or its authorized administrator will maintain records of the essential features of each Insured's insurance under this policy.

We have the right to examine the Policyholder's/Sponsoring Organization's records relating to coverage under this policy. Examination may occur at any reasonable time up to the later of:

- two years after this policy ends or
- the date of final adjustment and settlement of all claims under this policy.

POLICY TERMINATION

We may terminate this policy at any time. We will give at least 45 days notice before termination.

The Policyholder/Sponsoring Organization may terminate this policy at any time

We will refund any unearned premium from the date of termination.

Policy termination will not affect a claim for a loss due to an Accident that occurred while this policy was in effect.

CONFORMITY WITH STATE STATUTES

Any provision of this policy in conflict with the laws of the state where it is issued on the Policy Effective Date is amended to conform to the minimum requirements of such laws.

LEGAL ACTIONS

No legal action to recover under this policy can be brought for at least 60 days after We have been given written proof of loss. No legal action can be brought after three years from the time written proof of loss is required to be given to Us.

CERTIFICATES OF INSURANCE

We will deliver a certificate of insurance to the Policyholder/Sponsoring Organization for delivery by the Policyholder/ Sponsoring Organization to the Insured, in those states in which it is required. Each certificate will list the benefits, conditions, and limits of this policy. The Insured may request a printed copy of the certificate of insurance from the Policyholder.

DEFINITIONS

Accident means an unexpected and unintended event which:

- causes Injury to an Insured and
- occurs within the Scope of Coverage.

Ambulance Service (Air) means the service provided:

- by means of a fixed or roto-winged aircraft equipped with life support and medical apparatus and
- for the primary purpose of transporting an Insured to or from the Hospital where treatment is given.

Ambulance Service (Surface) means the service provided:

- by a commercial or municipal ground ambulance service and
- for transporting an Insured to or from the Hospital where treatment is given.

Activities of Daily Living (ADLs) means:

- transferring oneself (such as moving in or out of a bed or chair);
- dressing (putting on or removing from oneself items of clothing);
- bathing (washing oneself in a bathtub or shower or by sponge bath);
- feeding (giving oneself food or nourishment, including through a feeding tube);
- toileting (getting oneself on or off a toilet and related hygiene); and
- 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).

Allowable Expense means a Medical Expense payable under the policy that is not in excess of the 80th percentile identified on Context4HealthCare (the "Database"). When there is, in Our determination, minimal data available from the Database for a Medical Expense, We will determine the amount to pay by calculating the unit cost for the applicable service category using the Database and multiplying that by the relative value of the Medical Expense based upon a commercially available relative value scale selected by Us. In the event of an unusually complex medical procedure, a Medical Expense for a new procedure or a Medical Expense that otherwise does not have a relative value that is in Our determination applicable, We will assign a relative value. The Medical Expenses We pay may not reflect the actual charges of a provider and does not take into account the provider's training, experience, or category of licensure. A provider may charge the Insured the difference between what the provider charges and the amount We pay under the policy. The Database will be updated by Us as information becomes available from the supplier, up to twice each year. We may modify the Database in Our discretion to reflect Our experience. We have the right, in Our discretion, to substitute or replace the Database with another database or databases of comparable purpose, with or without notice.

Benefit Period means the period of time from the date of the Injury within which benefits will be paid for an applicable benefit provision. The Benefit Period is shown on the Schedule.

Controlled Substance means any drug or substance, other than alcohol, having the capacity to affect behavior and that is regulated by law with regard to possession and use.

Custodial Care means services or treatment, regardless of where provided:

- which could be rendered safely by a person without medical skills; and
- which provides a routine level of maintenance care designed mainly to help the patient with:
    - ADLs;
    - homemaking, such as preparing meals or special diets;
    - moving the patient;
    - acting as companion or sitter;
    - supervising medication which can usually be self-administered;
    - oral hygiene;
    - ordinary skin and nail care; and
    - cannot be self-administered.

Custodial Care does not include services or treatment provided by an Immediate Family Member or by a person who lives with the Insured, unless We specifically agree in writing. Custodial Care does not include Home Health Care services or treatment.

Date of Recovery means:

- for an Insured 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 24 consecutive months during which the Insured received no Medically Necessary care as a result of the Accident for which benefits had been received under this Policy;
- for an Insured 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:
    - the date the Insured receives medical clearance to participate in a Sponsored and Supervised Activity;
    - the date the Insured is released from treatment;
    - the date the Policyholder allows the Insured to return to participation in a Sponsored and Supervised Activity;
    - the date immediately following a period of 24 consecutive months during which the Insured received no Medically Necessary care as a result of the Accident for which benefits had been received under this Policy; or
    - For an Insured who was Totally Disabled, the date such Insured no longer qualifies as Totally Disabled as defined in this policy.

Deductible (Reducing) means the amount of eligible Medical Expenses incurred by an Insured before benefits are payable under this policy. Expenses must be incurred within the Deductible Establishment Period. Medical Expenses payable under any Other Insurance Plan will be used to satisfy or reduce this Deductible. It applies separately to each Insured and each Injury.

Deductible Establishment Period means the time period, beginning with the date of the Accident, in which the Deductible must be satisfied. This time period is shown on the Schedule.

Durable Medical Equipment means equipment that is Medically Necessary. It is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, and generally is not useful to anyone in the absence of an Injury.

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

- 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;
- 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;
- 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
- 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.

Extended Care Facility means an institution operating pursuant to applicable state law engaged in providing, for a fee, skilled nursing care and related services and physical therapy services under the supervision of a Physician and registered Nurses, to persons convalescing from illness or Injury. It must have facilities for 10 or more inpatients and maintain clerical records on all of its patients. To qualify as a Medical Expense under this policy, the Insured's confinement in an Extended Care Facility must:

- start within five days after the Insured has been continuously confined for at least five days in a Hospital as a result of an Accident;

- be for treatment of the Injuries resulting from such Accident;
- be one during which a Physician visits the Insured at least once every 30 days;
- be certified to be Medically Necessary by the attending Physician; and
- not be for routine Custodial Care.

Heart or Circulatory Malfunction means an acute onset of a cardiovascular or circulatory accident, stroke, or other similar traumatic event affecting the heart or circulatory system that:

- is first diagnosed and treated while the Insured's coverage under this policy is in force;
- occurs as a result of Injury to the Insured while participating in a Sponsored and Supervised Activity; and
- does not result from a Pre-Existing Condition.

Home Health Care means Nursing Care and treatment, to an Insured in his or her home, which is part of an overall extended treatment plan and a) is required for progressive and positive improvement of the Insured's medical condition and b) is necessary to provide care and treatment that cannot be self-administered.

To qualify as Home Health Care:

- the plan must be established and approved in writing by the attending Physician, including certification in writing by the attending Physician that confinement in a Hospital or Extended Care Facility would be required in the absence of Home Health Care and
- Nursing Care and treatment must be provided by a Hospital certified to provide Home Health Care services, by a certified Home Health Care agency or by an independently hired Nurse or Nurse Practitioner.

Home Health Care also means at home physical, speech, and occupational therapies when initiated in conjunction with discharge placement through a Rehabilitation Facility and approved by the attending Physician.

Home Health Care does not include services provided by an Immediate Family Member or a person who lives with the Insured, unless We specifically agreed to the services. Home Health Care does not include Custodial Care.

Hospital means an accredited facility licensed by the proper authority of the area in which it is located to provide care and treatment for the condition causing confinement. A Hospital will include a duly licensed state tax-supported institution regardless of whether or not it has an operating room and related equipment for the performance of surgery.

A Hospital does not include a facility or institution or part of a facility or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged, halfway house or board and care facilities.

Immediate Family Member means a spouse or a child, parent, grandparent, brother, or sister of the Insured, or step-relatives in these same categories, or a person who reared the Insured, or a person whom the Insured reared.

Injury or Injuries means bodily harm which:

- requires treatment by a Physician;
- results in loss due to an Accident, independent of sickness and all other causes; and
- occurs during a Sponsored and Supervised Activity.

Bodily harm does not include a Pre-Existing Condition or a Repetitive Motion Injury.

Insured means:

- a person as identified by the Policyholder/Sponsoring Organization and shown in the Eligibility section of the Schedule.

Internal Fixation means a surgical procedure that stabilizes and joins the ends of fractured bones by mechanical devices such as metal plates, pins, rods, wire, or screws.

Laboratory Tests means laboratory procedures identified in Physician Current Procedural Terminology (CPT) as codes 80000-89999 inclusive.

Loss Establishment Period means the time period shown on the Schedule, beginning with the date of the Accident, within which the following must occur:

- accidental death;
- a specific loss; or
- loss of life as a result of Heart or Circulatory Malfunction.

Loss of a Foot means Severance above the ankle.

Loss of a Hand means Severance at or above the wrist.

Loss of Hearing means total and permanent loss of hearing which cannot be corrected by any means.

Loss of Sight means the total, permanent loss of sight of the eye or eyes. The loss of sight must be irrecoverable by natural, surgical, or artificial means.

Loss of Speech means total, permanent, and irrecoverable loss of audible communication.

Loss of a Thumb and Index Finger of the same hand means Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand) from the same Accident.

Maximum Benefit Amount means the total benefits payable under an applicable benefit provision. The Maximum Benefit Amount is shown on the Schedule.

Medical Expenses means expenses incurred for Medically Necessary care.

Medically Necessary means care that is ordered, prescribed, or rendered by a Physician or Hospital, and that We determine, or a qualified party or entity We select determines, to be:

- consistent with the diagnosis and treatment of the loss;
- appropriate with the standards of good medical practice;
- not solely for the convenience of the Insured;
- the most appropriate supply or level of service which can be safely provided; and
- not considered Experimental or Investigational.

In the case of Hospital or Extended Care Facility confinement, Home Health Care 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 Custodial Care plan will be Medically Necessary only if We can reasonably determine that they are related to the care or treatment of the Insured's condition. The services or supplies must not be an Experimental or Investigational Drug or Treatment in nature. The fact that a Physician may prescribe, order, recommend, or approve care, a service or supply does not, of itself, make the care, service, or supply Medically Necessary.

Nurse means a professional, licensed, graduate registered nurse (RN), a professional licensed practical nurse (LPN) or a certified registered nurse anesthetist (CRNA).

Nurse Practitioner means a licensed registered nurse who has received special training for diagnosing and treating routine or minor ailments.

Nursing Care means care or treatment provided by a Nurse or Nurse Practitioner.

Orthopedic Appliances means braces and appliances that:

- are prescribed by a Physician;
- are primarily and customarily used to serve a medical purpose;
- can withstand repeated use; and
- are Medically Necessary.

Other Insurance Plan means any contract, policy, or other arrangement for benefits or services for medical or dental care or treatment under:

- any individual, group, blanket, or franchise policy of accident, disability, or health insurance;
- any arrangement of benefits for members of a group, whether insured or uninsured;
  any prepaid service arrangement such as Blue Cross or Blue Shield, individual or group practice plans, or health maintenance organizations;
- any amount payable for services for Injuries or diseases related to the Insured's job to the extent that he or she actually receives benefits under a workers' compensation law. If the Insured enters into a settlement to give up his or her rights to recover future Medical Expenses under a workers' compensation law, this policy will not pay those Medical Expenses that would have been payable except for that settlement; or
- 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 Tricare.

Paralysis means loss of function of one or more limbs as a result of neurological damage, without Severance of a limb. Paralysis must start within the Loss Establishment Period stated on the Schedule. This loss must be determined by a Physician to be complete and irreversible. The Insured must be under the care of a Physician for 1*1*2 consecutive months from the date of loss of function. At the end of this time, a Physician must determine that the loss of function is not reversible.

Physician means a legally qualified physician, Nurse Practitioner, or Physician's Assistant practicing within the scope of his or her license as recognized in the state where services are rendered. Physician does not include:

- the Insured; or
- an Immediate Family Member; or
- a person living with the Insured; or
- a person employed or retained by the Policyholder/Sponsoring Organization.

Physician's Assistant (PA) means a medical professional, other than the Insured, who is trained and licensed to provide basic medical services under the direction of a Physician.

Pre-Existing Condition means those conditions for which medical advice, diagnosis, care, or treatment was received or of recommended within the 12 months period immediately preceding the effective date of the Insured's coverage.

Prescription Drugs means drugs which:

- under Federal law may only be dispensed by written prescription and
- are approved for general use by the Food and Drug Administration.

Rehabilitation Facility means a legally operating institution or part of an institution which:

- has a transfer agreement with one or more Hospitals;
- is primarily engaged in providing comprehensive multi-disciplinary physical rehabilitative services or rehabilitation inpatient care; and
- is duly licensed by the appropriate government agency to provide such services.

Rehabilitation Facility does not include institutions which:

- provide only minimal care, Custodial Care, care for the terminally ill, or part-time care services or
- an institution which primarily provide treatment for mental disorders, chemical dependency, or tuberculosis, unless the 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. Such facility is required to be accredited by the Joint Commission on Accreditation of Healthcare Organizations, or the Commission on Accreditation of Rehabilitation Facilities.

Repetitive Motion Injury means conditions such as, but not limited to: bursitis, stress fracture, strain, shin splint, or tendonitis.

School means the participating school or school district where the Insured is enrolled. The School must be duly accredited (state certified or accredited) primary, elementary, secondary, or collegiate school.

Scope of Coverage means insurance coverage limited to a loss which:

- is within the scope of the risks specified in the INSURED RISKS section of this policy;
- is specified in the BENEFITS section of this policy;
- has satisfied the Deductible within the Deductible Establishment Period specified on the Schedule;
- occurs during the Loss Establishment Period on the Schedule, if any; and
- occurs while this policy is in effect.

Severance means the complete separation and dismemberment of the part from the body.

Spinal Manipulation is the 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.

Sponsored and Supervised Activity means a Policyholder/Sponsoring Organization authorized function:

- in which the Insured participates; and
- which is shown on the Schedule; and
- organized by or under its auspices and sanctioned by the appropriate governing authority; and
- within the scope of customary activities for such entity.

Sponsoring Organization means the legal entity to whom We issue this policy or that is affiliated with the Policyholder or that elects coverage under this policy.

Waiting Period means the period of time as shown in the Schedule during which benefits are not paid..

We, Our, Us means Mutual of Omaha Insurance Company.

X-ray means those procedures identified in Physician Current Procedural Terminology (CPT) as codes 70000-79999 inclusive.

Mutual of Omaha

3300 Mutual of Omaha Plaza
Omaha, NE 68175

EXCLUSIONS AND LIMITATIONS AMENDMENT RIDER

This rider is made a part of the policy or certificate to which it is attached. It is subject to all provisions and definitions as stated in your policy or certificate not in conflict with this rider. In the event of a conflict between this rider and any other provision of your policy or certificate, this rider will control.

Rider Date (same as the Policy Effective Date or certificate date if no date is shown)

EXCLUSIONS AND LIMITATIONS AMENDMENT

The following exclusion is added to the EXCLUSIONS AND LIMITATIONS section of your policy or certificate:

- Medical Expenses incurred after the Date of Recovery, except as specified in the Date of Recovery Benefit.

TERMINATION

This rider terminates when your policy terminates.

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary

NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA
LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted *in the box* below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is **NOT** provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
Post Office Box 10218
Raleigh, North Carolina 27605-0218

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. *On the next page* is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed the average rate specified in the law;
- dividends;
- experience or other credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.
- a policy or contract commonly known as Medicare Part C or Part D or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

(1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.

(2) Except as provided in (3) and (4) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter the number of policies or types of policies issued by the insolvent company.

(3) The guaranty association will pay a maximum of $500,000 with respect to basic hospital, medical and surgical insurance and major medical insurance.

(4) The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.

(5) The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.