

CONTRACT RENEWAL LETTER

Date: June 5, 2025

Contract Number: RU21039

Service: Intercollegiate Athletic Insurance

Renewal Term: July 1, 2025 to June 30, 2026 [Renewal No. 4 of 9]

Issued by: Radford University
Kevin McDowell, Contract Officer
540-831-5356, Email: dkmcdowel@radford.edu

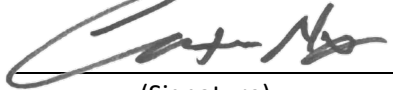
Contractor: HUB International Midwest Limited
750 Canyon Dr. Ste 450
Coppell, TX 75019
Contact Name: Chris Nixon Phone: 913-638-3718
Email: chris.nixon@hubinternational.com

Contract Administrator: Chad Hyatt, Associate Athletic Director of Sports Medicine
Phone: 540-831-5877 Email: mhyatt2@radford.edu

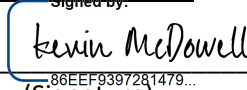
Description of Renewal Notice:

In accordance with the renewal provision of the original contract all terms, conditions, and specifications of the original contract remain the same during the contract renewal period, along with any modifications that have been incorporated up until this point.

HUB International Midwest Limited

By: 
(Signature)
Name: Chris Nixon
Title: Sr. VP Collegiate Sports
Date Signed: 6/6/25

RADFORD UNIVERSITY

Signed by:
By: 
(Signature)
Name: Kevin McDowell
Title: Sr. Contract Officer
Date Signed: 6/10/2025 | 12:48 PM EDT

2025-26 Premium Quotation

Option #4

2025-26 Policy Year - Radford University	
Maximum Benefit per Injury	\$90,000
Aggregate Deductible	\$150,000
Specific Deductible	\$0
Insured Percentage	100%
Initial Treatment Period	180 days
Benefit Period	104 weeks
Accidental Death and Dismemberment (AD&D)	\$10,000 per specific injury, \$500,000 aggregate maximum
Accidental Dental	Coverage included up to plan maximum (*Natural/Sound Tooth)
Expanded Medical	Included
Re-aggravation/Reinjury of Pre-Existing Conditions	Included
Heart & Circulatory	Included
HMO/PPO Denials	Included
Guest Recruit Coverage (including PSA tryouts)	Included
Proposed Effective Date	July 1, 2025

Covered Intercollegiate Sports

Baseball, Basketball, Cheer, Cross Country, Dance, Golf, Lacrosse, Soccer, Softball, Student Managers, Student Trainers, Tennis, Track & Field, Volleyball,

Annual Premium	\$14,000
Administration Fees	\$23,000
Total Hard Costs	\$37,000
Recommended upfront funding of claims account (negotiable)	\$75,000
Total initial funding request	\$112,000
Total potential maximum annual cost	\$187,000

Program Information

Insurance Carrier: Hartford Fire Insurance Company
 Claims Payer: A-G Specialty Insurance
 Broker/Program Coordinator: Dissinger Reed

Notice of Acceptance

By completing this Notice of Acceptance section with an authorized signature, you are confirming your intention to accept the above proposed insurance policy terms and conditions. Binding of coverage not finalized until received by the carrier.

_____	_____
Name	Title
_____	_____
Signature	Date

This is a summary of coverage. It does not contain all provisions, limitations and exclusions. Should any of the above assumptions and conditions change, we reserve the right to alter the quote.

Mutual of Omaha Insurance Company



New Business Proposal for:

**PROSPECTIVE STUDENT ATHLETE
CATASTROPHIC COVERAGE**

T5MP-P-To be determined (in MD)

SB20CC-P-To be determined (CA, CO, ID, KY, MT, NJ, SD, WA & WY)

SB21CC-P- To be determined (All remaining states except DE, NH & NY)

*We will be the kind of company
our customers value, people admire
and our competitors envy.*

PROPOSED PLAN OF INSURANCE

Name of Policyholder:	To Be Determined XXXXXXXXXX XXXXXXXXXX
Policy Number:	To be determined
Term of Coverage:	To be determined
Annual Premium:	Option 1: \$600.00 Option 2: \$900.00
<ul style="list-style-type: none">The annual premium shown above is fully earned and non-refundable on the date coverage goes into effect.	
Eligibility:	Prospective Student Athletes on a campus visit.
Covered Event:	<p>Coverage is provided during activities/events authorized by, organized by or directly supervised by an official representative of the Policyholder. The activities/events must be during and directly related to a campus visit for which the athlete was invited by the Policyholder.</p> <p>No coverage is provided for a Prospective Student Athlete that has graduated from high school and signed an irrevocable commitment to participate in an Intercollegiate Sport for the Policyholder.</p> <p>Travel Coverage (as defined in the policy) is only effective for activities conducted under direct supervision of an official representative of the Policyholder.</p>
Aggregate Limit of Liability:	Option 1: \$5,000,000.00 Option 2: \$10,000,000.00
<ul style="list-style-type: none">This is the maximum amount for which We are liable for an Insured Person for all benefits under this plan due to any one Accident.	
Covered Accident Deductible:	\$90,000.00
<ul style="list-style-type: none">Eligible medical expenses payable under any other insurance policy or service contract will be used to satisfy or reduce the Covered Accident Deductible.	
Medical, Dental, Rehabilitative and Custodial Care Expense Benefits – Full Excess:	
Benefit Percentage	100%
Deductible Establishment Period	24 Months
Maximum Benefit Period	10 Years from accident date
Maximum Benefit Amount	Option 1: \$5,000,000.00 Option 2: \$10,000,000.00

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	Usual and Customary Charges
Combined Home Health Care and Custodial Care	
Maximum Benefit per Calendar Year	\$100,000.00 (No Benefit in MD)
Custodial Care Maximum Benefit per Calendar Year	
subject to the Combined Home Health Care and	
Custodial Care Maximum Benefit per Calendar Year	\$100,000.00 (No Benefit in MD)
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 (No Benefit in MD)
Treatment of Mental or Nervous Disorders	
Doctor Fees –	
Amount per Visit	\$50.00
Visits per Day	1
Number of Visits per Calendar Year	50
Inpatient Hospital	Up To 45 Days
Maximum Chiropractic Benefit	
Maximum Amount per Calendar Year	\$1,000.00
Maximum Visits per Calendar Year	N/A
Maximum Outpatient Physical Therapy Benefit	
Maximum Amount per Calendar Year	\$75,000.00
Maximum Visits per Calendar Year	N/A
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 above the knee	\$200,000.00
Maximum Benefit Amount	\$200,000.00
If amputation of the leg above the knee	\$300,000.00
Loss of Life Due To Heart or Circulatory Malfunctions Benefit:	
Loss Establishment Period	90 Days
Maximum Benefit Amount	\$10,000.00
Accidental Death, Dismemberment, Loss of Sight, Speech or Hearing Benefit:	
Principal Sum	\$10,000.00
Loss Establishment Period	365 Days

EXCLUSIONS AND LIMITATIONS

No benefits are payable for:

- Repetitive Motion Injuries or the aggravation thereof;
- bacterial infection, except infection of and through a wound accidentally sustained;
- loss from intentionally self-inflicted injury, suicide while sane or insane;
- loss from commitment of or an attempt to commit a felony, or engagement in an illegal activity;
- loss from an act of declared or undeclared war;
- loss from participation in a riot or insurrection;
- 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;
- charges which exceed the Allowable Expense;
- charges incurred for dental work unless the Insured sustains an Injury which results in damage to his or her natural teeth;
- 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;
- charges incurred for services or supplies not specifically provided for in the policy;
- charges which would not have been made in the absence of insurance or which the Insured is not legally obligated to pay;
- charges incurred for cosmetic procedures, unless made Medically Necessary by an Injury;
- 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;
- charges incurred for care, treatment, or service which is not Medically Necessary to the diagnosis or treatment of an Injury;
- charges incurred for the professional services of a person who either lives with the Insured or is an Immediate Family Member;
- charges incurred for Custodial Care services or treatment;
- charges incurred for Experimental or Investigational Drug or Treatment;
- charges incurred for articles of clothing which are intended for use more than once;
- routine medical examination and related medical services;
- charges which are recoverable from any other insurance policy, service contract, Workers' Compensation, or other arrangements of insured or self-insured group coverage;
- charges for mental or nervous disorders, except as specifically provided herein;
- elective treatment or surgery, health treatment, or examination where no Injury is involved;
- acts of aggression, assault, or battery (only if instigated by the Insured);
- fighting or brawling (other than an act of aggression instigated by an Insured);
- drugs that promote fertility, treat infertility, enable sexual performance, or provide sexual enhancement;
- 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;
- 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;
- treatment in any Veterans Administration or federal Hospital, unless there is a legal obligation to pay;
- Pre-existing Condition;
- active duty service in any Armed Forces;
- voluntary self-administration of any drug or chemical substance not prescribed by or not taken according to the directions of the Physician;
- Injury caused by, attributable to, or resulting from the Insured's Intoxication;
- Injury caused by, attributable to, or resulting from the Insured's use of a Controlled Substance unless administered on the advice of a Physician and taking the prescribed dosage;
- operating a motor vehicle under the influence of a Controlled Substance unless administered on the advice of a Physician and taking the prescribed dosage;
- 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;
- services or treatment incurred to the extent they are paid or payable under any Other Insurance Plan;
- services or treatment incurred to the extent that they are paid or payable under any automobile insurance policy without regard to fault. This exclusion does not apply in any state where it is prohibited;
- Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any Other Insurance Plan;
- charges incurred for Home Health Care services or treatment.

Exclusions are dependent on the policy form used to issue coverage.



**MUTUAL OF OMAHA INSURANCE COMPANY
PROSPECTIVE STUDENT ATHLETE
CATASTROPHIC MEDICAL INSURANCE FORM**

1. Policyholder Radford University
 Address 101 University Dr
 City, State & Zip Radford, VA 24142

2. Coverage & Premium Options (Please choose only one option):

OPTION	MAXIMUM BENEFIT	BENEFIT PERIOD	ANNUAL PREMIUM
<input type="checkbox"/> A	\$5,000,000	10 Years	\$600.00
<input checked="" type="checkbox"/> B	\$10,000,000	10 Years	\$900.00

3. Requested Date of Coverage*: 07/01/2025.

*Coverage will be effective at 12:01am on the day after the school signs up. All coverage will expire one year from the effective date.

Signature below and on the SR2014 App (when required) will acknowledge that the above Policyholder accepts Mutual of Omaha's proposal and agrees to the benefit limits as set forth in the proposal.

Signed by:


 Policyholder Signature
 Sr. Contract Officer

 Title or Position
 6/10/2025 | 12:48 PM EDT

 Date Signed

For questions regarding the coverage contact the following:

**HUB International Kansas
& Missouri**
 9200 Ward Parkway, Suite 500
 Kansas City, MO 64114
 913-491-6385

MUTUAL OF OMAHA INSURANCE COMPANY

Mutual of Omaha Plaza
Omaha, NE 68175



Home Office Use Only

Policy Number(s): _____

Participant Accident Insurance Application

Applicant (Full Legal Name) Radford University

Address 101 University Drive

City Radford State VA Zip 24142

Requested Effective Date 07/01/2025

If this application is approved, insurance will become effective on the requested effective date, unless Mutual of Omaha Insurance Company sends written notice of a different effective date.

ACKNOWLEDGMENT AND SIGNATURE

All statements in this application and any claims experience data provided to Mutual of Omaha Insurance Company are true and complete and will be relied upon by Mutual of Omaha Insurance Company to determine whether to issue a policy. Such statements and claims experience data, along with the group insurance proposal from Mutual of Omaha Insurance Company, are the basis for any policy issued by Mutual of Omaha Insurance Company. Any incomplete, incorrect or misleading statements or data may void this application and any issued policy as of the effective date.

If an authorized representative at Mutual of Omaha Insurance Company's Home Office does not approve this application, no insurance is in effect at any time and any premium payment received will be returned.

This application is submitted with a premium payment of \$ 900.00

Signed by:
Kevin McDowell
96EEF0307281470...

Signature of Applicant's Authorized Representative _____

Typed or Printed Name of Authorized Representative Kevin McDowell

Title Sr. Contract Officer **Date** 6/10/2025 | 12:48 PM EDT

Name of broker, agent and/or insurance agency Chris Nixon - Dissinger Ree

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, may be guilty of a crime and may subject such person to criminal and civil penalties.

Kansas Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, may be guilty of a crime and may subject such person to criminal and civil penalties as determined by a court of law.

Louisiana, West Virginia Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Ohio, Virginia Fraud Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.