Student Accident Insurance
Standard Group - $10,000 Per Injury Plan
Policy GA-2200Ed.11-16(KS)

SUMMARY OF GROUP COVERAGE

The school purchased a group insurance policy that will provide benefits for accidental bodily injury incurred while the student is:

a. attending regular school sessions,
b. participating in or attending school-sponsored and supervised extracurricular activities,
c. participating in school-sponsored and supervised KSHSAA interscholastic sports and activities, and
d. traveling by way of biking or walking directly to and from school for regular school sessions; and while traveling in school provided transportation to or from any school sponsored and supervised extracurricular and interscholastic sports activities. Excludes non-school provided motorized transportation of any kind.

OTHER COVERAGE OPTIONS TO PURCHASE

PARENTS: Now you may extend this valuable school-time protection by purchasing the following coverage options:

A. 24-HOUR ACCIDENT COVERAGE (FULL-TIME) - Covers your student 24-hours a day, any time or anywhere, until school starts next year. Provides benefits for doctor, hospital and dental expenses arising from an accidental injury.

B. EXTENDED DENTAL ACCIDENT COVERAGE - Provides benefits up to a maximum of $5,000 for any dental Injury. Covers the student 24 hours a day until school starts next year. Treatment must begin within 60 days from the date of the Injury and must be performed within one year from the date of Injury. However, if within the one year period following the date of Injury the student's attending dentist certifies that dental treatment and/or replacement must be deferred beyond one year, the policy pays the estimated cost of such deferred treatment, but not to exceed $200 for each tooth. Benefits for prostheses are limited to $500 per injury, including procedures performed to install them. Dental prostheses include, but are not limited to: crowns, dentures, bridges, and implants. Extended Dental does not cover treatment for orthodontics and dental disease, or expenses that exceed the dental prosthesis maximum benefit limit.

HOW TO ENROLL: Complete the attached enrollment form, enclose with your premium payment and mail to: (DO NOT SEND TO SCHOOL)
Student Assurance Services, Inc. P.O. Box 196, Stillwater, MN 55082
The Medical Benefits and Exclusions below apply to the summary and coverage options above

MEDICAL BENEFITS

When injury covered by the Policy results in treatment by a licensed physician within 60 days from the date of injury, the Company will pay the usual and customary (U&C) expenses incurred for covered services as listed below, for expenses actually incurred within one year from the date of injury up to a maximum of **$10,000 per injury**. Unless stated otherwise, all amounts listed below are per injury.

The Company's liability for benefits payable on account of expense incurred, for any hospitalization, medical, surgical, and other services resulting from covered Injury of the covered person, shall be limited to that part of the expense, if any, which is in excess of the total benefits payable for the same loss, on a provision of service basis or on an expense incurred basis under any medical or service contract, self-funded plan, automobile medical payment coverage, or any plan under federal, state or local law (except Medicaid). If one or more of the other policies, plans or service contracts provides benefits on an excess insurance or an excess coverage basis, benefits should be paid first by the company or service plan whose policy or service contract has been in effect for the longer period of time at the date of such loss.

PHYSICIAN'S SERVICES
a) Surgical Care (surgeon, assistant surgeon, anesthesia) - 80% U&C, up to $2,000
b) Nonsurgical Care (does not include physiotherapy) - U&C, up to $50 per visit, maximum 10 visits

PHYSIOTHERAPY (any form of therapeutic or manual treatment provided by a physician, including but not limited to: physical or mechanical therapy, diathermy, ultrasonic, whirlpool or heat treatments, EMS, or manipulation, includes office visit) - U&C, up to $50 per visit, maximum 5 visits

HOSPITAL CARE
a) Inpatient Care
- Hospital Semi-private Room - U&C, up to $450 per day
- Hospital Miscellaneous Services - 80% U&C, up to $3,000

b) Outpatient Care (includes facility charges for day surgery and emergency room) - 80% U&C, up to $500

NOTE: Benefits for hospital miscellaneous and outpatient care charges are limited to services not scheduled under Medical Benefits.

RADIOLOGY SERVICES (includes x-ray, MRI, CT scan, bone scan, and charges for reading) - 80% U&C, up to $400

DENTAL TREATMENT (in lieu of all other medical benefits; for repair and/or replacement of each sound and natural tooth) - U&C, up to $200 per tooth

AMBULANCE SERVICES - 80% U&C, up to $400

ORTHOPEDIC APPLIANCES (when prescribed by a physician for healing) - U&C, up to $200

PRESCRIPTION DRUGS (take home) - U&C, up to $200

REPLACEMENT EYEGLASSES AND HEARING AIDS (when medical treatment is required for covered injury) - U&C, up to $200

MOTOR VEHICLE INJURY - Same as any Injury

The policy contains a provision limiting coverage to usual and customary charges. This limitation may result in additional out-of-pocket expenses for the insured.

STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER MN 55082-0196

IS YOUR CHILD PROTECTED?

ACCIDENTAL DEATH AND DISMEMBERMENT

When injury covered by this policy results in Accidental Death or Dismemberment within 180 days from the date of accident, the following benefits will be payable.

Loss of Life.....$2,000 Single Dismemberment.....$2,000 Double Dismemberment.....$10,000

EXCLUSIONS - No Benefits Will Be Allowed For:

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.
2. Injuries for which benefits are payable under Workers' Compensation or Employer's Liability Laws.
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. Replacement of contact lenses or prescriptions or examinations thereof.
5. No benefits are payable for accidental bodily Injuries arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used including such benefits mandated by law) of any automobile policy.

IT IS NOT THE INTENT OF THIS POLICY TO PROVIDE BENEFITS FOR AN EXISTING MEDICAL PROBLEM. A re-injury will be covered if the insured has been treatment free for a period of 180 days prior to the effective date of the policy.

CLAIM PROCEDURE

Filing of the claim is the parent's responsibility.

1. Parents notify the school and obtain a claim form immediately. The school completes Part A of the claim form if it's a school injury.
2. Parents complete Part B of the claim form. Answer all questions.
3. Parents submit copies of the student's itemized bills to the student's family medical or dental coverage first, even if there is a large deductible. The other insurance plan will send a report called an Explanation of Benefits (EOB).
4. Parents send the completed claim form, copies of the student's itemized bills and the EOB to:

   STUDENT ASSURANCE SERVICES, INC.
   PO BOX 196
   STILLWATER MN 55082
5. The claim will be completed when all of the above documents have been provided. For claim questions, contact Student Assurance Services, Inc. at (800) 328-2739.

NOTE: Student must have been treated by a licensed physician within **60 days** of the date of injury. Proof of claim should be submitted within 90 days from the date of accident, or a reasonable time thereafter not to exceed one year. Itemized bills should be submitted within 90 days from the date of treatment or a reasonable time thereafter not to exceed one year. The Company is responsible only for expenses incurred within one year.

EFFECTIVE AND EXPIRATION DATES

Coverage becomes effective on the Master policy effective date; or the first day of state authorized KSHSAA interscholastic sports or activity; or the first day of the regular school session; or for Full-Time coverage at 12:01 AM following the date the envelope containing the enrollment form and premium is postmarked by the U.S. Postal Service. KSHSAA coverage will expire on the last day of the state authorized interscholastic sports season or activity of the current school year. School-Time and Full-Time coverage will expire the first day of the regular school session next year.

This provides a very brief description of some of the important features of the insurance policy. It is not the insurance policy and does not represent it. A full explanation of benefits, exceptions and limitations is contained in the Group Accident Insurance Policy Form GA-2200Ed.11-16 (and any state specific), and any applicable endorsement(s). This policy is considered term accident insurance and is non-renewable. This product may not be available in all states and is subject to individual state regulations. The Master Policy is issued to the School District/School. A copy of the Privacy Notice and Certificate of Coverage may be obtained on the website www.sas-mn.com

Underwritten by

Ameritas

Ameritas Life Insurance Corp.
Lincoln, Nebraska

Administered by
STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MINNESOTA 55082

D-5636(2018) (17)

Enrollment Form for Student Accident Insurance

Ameritas

Ameritas Life Insurance Corp.
Lincoln, Nebraska

- ❑ **24-HOUR COVERAGE $85**
- ❑ **EXTENDED DENTAL COVERAGE $7**
- ❑ **24-HOUR COVERAGE AND EXTENDED DENTAL COVERAGE $92**

One time policy year premiums. Make your check payable to and mail to: Student Assurance Services, Inc. P.O. Box 196, Stillwater, MN 55082-0196

Name of Student _____ Age _____ Grade _____
(Please Print)

Address _____ Phone _____
(Street)

City _____ State _____ Zip _____

Name of School _____ Name of District _____

Signature of Parent/Guardian _____ Date _____

GAA-2203Ed.11-16 **Attach Premium Check - NO REFUNDS - Premium cannot be prorated** D-5636(2018)(17)