# STUDENT ACCIDENT INSURANCE COVERAGE

POLICY GA-2200Ed.11-16(ID)(KS)(LA)(MN)(MT)(NC)(ND)(OH)(SD)

| Premiums & Coverage Options | One Time Policy Year Premiums |
|---|---|
| **School Time Coverage Grades PK-12 (Does NOT Include Interscholastic Sports Coverage grades 7-12)** Protects the student while: a) attending regular school sessions, b) participating in or attending school-sponsored and supervised extracurricular activities, c) traveling directly to and from school for regular school sessions, and while traveling to and from school-sponsored and supervised extracurricular activities in school provided transportation. DOES NOT cover participation in interscholastic sports for students in grades 7-12. | $16 |
| **Full Time Coverage Grades PK-12 (Does NOT Include Interscholastic Sports Coverage grades 7-12)** Covers the student 24 hours a day until school starts next year. Includes coverage while at home and school, on weekends and during summer vacation. DOES NOT cover participation in interscholastic sports for students in grades 7-12. | $99 |
| **School Time Coverage Grades PK-12 AND Interscholastic Sports Coverage Grades 7-12 (does not include Football grades 9-12)** In addition to School-Time Coverage shown above, includes All Interscholastic Sports Coverage that protects the student while practicing for or competing in school-sponsored and supervised interscholastic sports including travel in school provided transportation for grades 7-12. DOES NOT cover Football for grades 9-12. | $91 |
| **Full Time Coverage Grades PK-12 AND Interscholastic Sports Coverage Grades 7-12 (does not include Football grades 9-12 )**In addition to the Full-Time Coverage shown above, includes All Interscholastic Sports Coverage that protects the student while practicing or competing in school-sponsored and supervised interscholastic sports including travel in school-provided transportation for grades 7-12. DOES NOT cover Football for grades 9-12. | $174 |
| **Football Coverage Grades 9 - 12** Protects the student while practicing for or competing in school-sponsored and supervised interscholastic football including travel in school-provided transportation for grades 9-12. | $250 |
| **Extended Dental Coverage Grades PK-12** 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, dental disease, or expenses that exceed the dental prosthesis maximum benefit limit. | $9 |

**The Medical Benefits and Exclusions below apply to the Coverage Options listed above.**

**MEDICAL BENEFITS (What the Insurance Plan Pays)** - When injury covered by the policy results in treatment by a Licensed Physician within 60 days from the date of accident, the Company will pay the Usual and Customary Charges (U&C) incurred for covered services as listed below, for charges actually incurred within one year from the date of injury up to the specified Maximum Medical Benefit of $50,000 per injury. (In MT and NC benefits are payable after the deductible per injury is satisfied, the deductible is the amount paid or payable for the same injury by Other Valid Coverage)

This policy will pay benefits regardless of Other Valid Coverage if the covered claim expense is less than $200. If the covered claim expense exceeds $200, benefits shall be paid first by Other Valid Coverage. (This coverage is excess in KS, and this coverage is primary in MT and NC after deductible, and in ID, IL)

**All Amounts Listed Below are Per Injury**

**PHYSICIAN'S SERVICES**
a) **Surgical Care** (surgeon, assistant surgeon, and anesthesia) ..... 80% U&C, up to $2,500
b) **Nonsurgical Care** (includes physiotherapy performed other than in a hospital, 1 visit per day)..... U&C, up to $50 per visit, maximum 6 visits

**HOSPITAL CARE**
a) **Inpatient Care**
1) **Hospital Semi-Private Room** ..... U&C, up to $500 per day
2) **Hospital Miscellaneous Services** ..... 80% U&C, up to $2,500
b) **Outpatient Care**
1) **Facility Charges for Day Surgery** ..... U&C, up to $2,500
2) **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.**

**X-RAY SERVICES** (includes charges for reading) ..... U&C, up to $250
**LABORATORY SERVICES** ..... U&C, up to $250
**DIAGNOSTIC IMAGING** (includes MRI, CT scan, bone scan and charges for reading) ..... U&C, up to $500
**DENTAL TREATMENT** (in lieu of all other medical benefits; for repair and/or replacement of each sound and natural tooth) ..... U&C, up to $250 per tooth (In SD, sound and natural is deleted)
**AMBULANCE SERVICES** ..... U&C, up to $500
**ORTHOPEDIC APPLIANCES** (when prescribed by a physician for healing) ..... U&C, up to $250
**PRESCRIPTION DRUGS** (take home) ..... U&C, up to $250
**REPLACEMENT EYEGLASSES, CONTACT LENSES, HEARING AIDS** (when medical treatment is required for covered injury) ..... U&C, up to $250
**MOTOR VEHICLE INJURY** ..... Same as any injury, up to $2,500 (In KS,$2,500 limit does not apply)

## 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 ..... $2,500 Loss of an Eye ..... $2,500 Double Dismemberment ..... $10,000 Single Dismemberment ..... $2,500

**The policy contains a provision limiting coverage to the usual and customary charges. This limitation may result in additional out-of-pocket expenses for the insured.**
**I-1511/1513(2023)**

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Ameritas
Ameritas Life Insurance Corp.
Lincoln, Nebraska

## ENROLLMENT FORM FOR STUDENT ACCIDENT INSURANCE

↑ STUDENT'S LAST NAME ↑ (one letter in each box)

STUDENT'S FIRST NAME M.I.
*Please Print*
Address _____
(Street)

_____
(City) (State) (Zip)

Email Address _____

Name of School _____

Name of District _____

Student's Age_____ Grade_____Phone _____

X _____
GAA-2203Ed.11-16 (Signature of Parent or Guardian) (Date)

| COVERAGE PLANS | One Time Policy Year Premiums |
|---|---|
| **Full Time Coverage** (Does NOT include Interscholastic Sports Coverage) | ☐ $ 99 |
| **Full Time Coverage AND Interscholastic Sports Coverage** (Does not include Football Grades 9-12) | ☐ $174 |
| **School Time Coverage** (Does NOT Include Interscholastic Sports Coverage) | ☐ $ 16 |
| **School Time Coverage AND Interscholastic Sports Coverage** (Does not include Football Grades 9-12) | ☐ $ 91 |
| **Football Coverage** (Grades 9-12 ) | ☐ $250 |
| **Extended Dental Coverage** (Grades PK-12) | ☐ $ 9 |

**DO NOT SEND CASH** **TOTAL PREMIUM**

Make Checks payable to: **STUDENT ASSURANCE SERVICES, INC.**
*Please write student's name on the front of check. **NO REFUNDS**

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## EXCLUSIONS (What the Plan DOES NOT Pay)

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 paid under Workers' Compensation or Employer's Liability Laws. (In NC, benefits are excluded if the employee, employer, or carrier is responsible or liable according to final adjudication or settlement order under state law)
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. (In ID, Insured must be participating as a professional)
4. The practice or play of interscholastic sports including travel to or from such activity, practice, or play for students in grades 7-12, unless such premium is paid.
5. In Kansas - 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.
6. In Ohio - Reinjury if the insured participated in a covered activity against medical advice.

**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. (In OH, this provision does not apply)**

**WHAT KIND OF INSURANCE IS THIS?**
This is accidental bodily injury insurance; it covers accidental bodily injury occurring while the coverage is in force. Medical illnesses such as ear infections or sore throats are not covered.

**WHO SHOULD CONSIDER BUYING THIS INSURANCE?**
1. All families with no other health coverage.
2. Families with other medical or dental coverage having deductibles, copays or coinsurance. Our policy applies benefits toward your other health coverage out-of-pocket expenses. (This coverage is primary in MT and NC after deductible, and in ID, IL)

## HOW TO ENROLL

1. Select the desired coverage(s) from the options listed above. Premium cannot be prorated. There are two enrollment and payment options.
2. Complete the Enrollment Form and enclose the premium (check made payable to: STUDENT ASSURANCE SERVICES, INC. or credit card payment information). Please write the name of the student on the check. Return the premium payment with the requested enrollment information in an envelope and mail to: Student Assurance Services, Inc. P.O. Box 196, Stillwater, MN 55082-0196; OR
3. Complete enrollment form online at the Student Assurance Services, Inc. website www.sas-mn.com. The online form is available under the K-12 School Look-up.
4. Be sure to retain this brochure and a copy of the premium payment as proof of insurance. You will not receive a policy or ID card. The master policy is issued to the school.

## EFFECTIVE AND EXPIRATION DATES

Coverage becomes effective the later of: the Master Policy Effective Date; r 12:01A.M. following the date the envelope containing the enrollment form and premium payment is postmarked by the U.S. Postal Service; or for online enrollment 12:01A.M. following the date the proper premium is received by the Plan Administrator. Interscholastic sports coverage expires on the last day of the authorized season of the current school year. School-Time and Full-Time coverage expires on the first day of school next year.

## HOW TO FILE A CLAIM

1. Notify the school and obtain a claim form immediately. The school will fill out 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. Submit copies of the student's *itemized bills* to the student's family medical and dental coverage first, even if there is a large deductible. The other insurance plan will send a report called an Explanation of Benefits (EOB). This plan is supplemental to all other valid coverage. The claim must be filed with the other coverage first! (Coverage is excess in KS, primary in MT and NC after deductible, and in ID, IL) This Plan **DOES NOT** cover penalties imposed for failure to use providers preferred or designated by the primary coverage. (In KS, penalty does not apply)
4. Send the completed claim form, copies of student's itemized bills and EOB to:
   STUDENT ASSURANCE SERVICES, INC.
   PO BOX 196 • STILLWATER, MN 55082
5. No claim can be completed until **all of the above documents** have been provided.

NOTE: Student must be treated by a Licensed Physician within 60 days of the date of the 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 reasonable time thereafter not to exceed one year. The policy is responsible only for expenses incurred within one year. (In NC, itemized bills must be submitted within 180 days from the date of treatment, not to exceed one 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 (except in ID) 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 (where applicable) may be obtained on the website www.sas-mn.com.

**I-1511/1513(2023)**

Administered by

**STUDENT ASSURANCE SERVICES, INC.**
**PO Box 196 • Stillwater MN 55082-0196**
**Toll Free 800-328-2739 - (651) 439-7098**

**www.sas-mn.com**

STUDENT ASSURANCE SERVICES INCORPORATED

**HAVE QUESTIONS?**
**CALL US TOLL FREE AT**
**(800) 328-2739 OR (651) 439-7098**

Underwritten by

Ameritas
Ameritas Life Insurance Corp.
Lincoln, Nebraska

## STUDENT ACCIDENT INSURANCE CREDIT CARD PAYMENT

INDICATE PREMIUM SELECTED AND COMPLETE THE REQUESTED ENROLLMENT INFORMATION FOUND ON THE REVERSE SIDE OF THIS FORM.

***There is a $5.00 Processing Fee added to ALL Credit Card Transactions (does not apply to IN, NC residents)***

☐ Please charge $ _____ + $5.00 Processing Fee = $ _____ to the following credit card: ☐VISA® ,☐MasterCard®, or ☐Discover®

Credit Card Number

Security Code (on back of card, 3 digits)

Card Expiration Date (Month) (Year)

Credit card billing will state: "Student Assurance Services, Inc."

Print Cardholder Name _____ Date ____ / ____ / ____

Cardholder Signature _____

Cardholder Address _____
(Street) (City) (State) (Zip)

Telephone Number (_____ ) _____ - _____

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**DETACH - Place inside envelope**