CATASTROPHIC ACCIDENT INSURANCE

2022 – 2023 School Year

BENEFIT SUMMARY

- Provides Accident Medical Expense Benefits with a maximum benefit of $5,000,000 per Insured per Covered Accident. Accident Expense Benefits are payable:
  (a) after $25,000 of covered expenses have been incurred within two years after the date of the Covered Accident; and
  (b) after benefits have been paid under other Health Care Plans; and
  (c) for Covered Expenses incurred within 10 years from the date of the Covered Accident.
- Provides an Accidental Death benefit of $10,000, and a Dismemberment benefit of up to $20,000.

CLASS DESCRIPTION & COVERAGE

- CLASS 1: All student athletes, student managers, student trainers, student coaches, cheerleaders and band members who participate in school sponsored and supervised interscholastic athletic activities.
- CLASS 2: All students, from pre-kindergarten through the twelfth grade, while they are attending regularly scheduled classes and taking part in all school-sponsored and supervised activities including off-season athletic training and conditioning, except interscholastic athletics. (Includes Class 3 students, if Class 2 students are covered under the Policy)
- CLASS 3: All students who participate in all school-sponsored and supervised extracurricular non-athletic activities and clubs.

PREMIUM

- CLASS 1: Rate is based on the *total enrollment* of each High School & Junior High, not just athletes.
  If you need Class I Sports Coverage for Junior High & 9th Grade, but the 9th Grade is in a different building, add the total number of 9th Grade students to the enrollment of the Junior High and use the corresponding Junior High rate.

RATE PER BUILDING

Number of Students in each High School		Number of Students in each Junior High	
0-200	$ 250	0-100	$ 150
201-400	$ 350	101-250	$ 200
401-1,000	$ 600	251-500	$ 400
1,001-1,400	$ 1,250	501-750	$ 650
1,401 & up	$ 1,650	751 & up	$ 1,000

- CLASS 2: $1.20 per student
- CLASS 3: $0.40 per student

100% participation is required - Minimum Policy Premium - $500.00

HOW TO ENROLL

- Please complete the attached APPLICATION
- Include your check with the APPLICATION made payable to Student Assurance Services, Inc.
- Please send the APPLICATION and check to:

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

This brochure provides a summary of the coverage to be provided and is not intended to substitute for or duplicate policy provisions. It is subject to the provisions of the policy of insurance to be issued by Great American Insurance Company. You will need to contact us for exact policy language, as well as for any limitations and restrictions that may be applicable. The policy is the only contract between the Policyholder and us. It contains the actual terms, conditions and limits of the coverage to be provided. If there is any conflict between this quote and the policy, the policy will govern in all cases. Acceptance of this quote is contingent upon and subject to the actual terms and conditions of the policy as issued.

CONTACT INFORMATION

- Marketed by: Student Assurance Services, Inc.
  333 North Main Street
  P.O. Box 196
  Stillwater, MN 55082-0196
  Phone (651) 439-7098 – Toll Free 1-800-328-2739

- Underwritten by: Great American Insurance Group
  Cincinnati, Ohio 45202

- **Description of Coverage**
  This plan provides benefits for Covered Expenses incurred for treatment of injuries resulting directly, and independently of all other causes, from a Covered Accident. The Covered Accident must occur while the student is taking part in the activity described in the Covered Activity(ies), or while traveling, via transportation provided by the school, directly to or from an activity as a member of a group supervised by the school.
- **General Limitations**
  Benefits are payable only for Covered Losses incurred as a result of participation in Covered Activities.
  LIMITATION ON MULTIPLE COVERED ACTIVITIES: If an Insured suffers a Covered Loss while participating in more than one Covered Activity, We will pay only one benefit, the largest benefit unless there is a specific written exception in this Policy. LIMITATION ON MULTIPLE BENEFITS: If an Insured can recover benefits under more than one of the Benefits stated in the Schedule, as a result of the same Accident, We will pay only one benefit, the largest benefit.

- **Accident Medical Expense Benefits**
  If, as a result of a covered Injury, the Insured, requires care and treatment rendered by a doctor, the Company will pay the Usual and customary charges which are deemed medically necessary provided the first expense is incurred no later than 180 days after the date of the Covered Accident. This Benefit is payable subject to the Benefit Maximum per Covered Accident, the Deductible, and the Maximum Benefit Period shown in the Application.
  The benefit amount for this benefit is payable in excess of any In Force Policy and its applicable deductible. In the event and only in the event of the reduction or exhaustion of the limit of insurance of the In Force Policy solely as the result of actual payment of benefits covered thereunder, this Policy shall pay excess of the reduced limit of insurance of the In Force Policy and its applicable deductible. This Policy shall only pay pursuant to the terms and conditions of this Policy and no other policy. We will pay the Usual and Customary amount, reduced by the payment by any other insurance plan. This Policy will recognize payment by any other insurance plan as reducing or satisfying the deductible amount of this Policy.
- **Accidental Death and Dismemberment Benefit**
  If an Insured suffers a loss of life as a result of a Covered Injury, We will pay the applicable amount shown in the Schedule. The death must occur within 365 days of the Covered Injury.
- **Accidental Dismemberment Benefit**
  If a Covered Injury to an Insured results in any of the following Covered Losses, We will pay the percentage shown below. The Covered Loss must occur within 365 days of the Covered Accident. The benefit amount is based on the maximum amount shown in the Schedule for the person suffering the Covered Loss.

Covered Loss	Percentage of Maximum Amount	Covered Loss	Percentage of Maximum Amount
Both Hands or Both Feet	100%	Sight of Both Eyes	100%
One Hand or One Foot plus the loss of Sight of One Eye	100%	Speech and Hearing	100%
One Hand; One Foot; or Sight of One Eye	50%	Hearing in One Ear	25%
Thumb and Index Finger of the same Hand	25%		

- For purposes of this Benefit, DEFINITIONS is amended to include the following: Covered Loss means:

1. For a foot or hand, actual severance through or above the ankle or wrist joint;
2. For thumb and index finger, complete severance through or above the metacarpophalangeal joint of Both digits;
3. Total and permanent loss of sight;
4. Total and permanent loss of speech; or
5. Total and permanent loss of hearing.

- **General Exclusions -** A loss will not be a Covered Loss if it is caused by, contributed to, or results from:

1. Sickness, disease, mental infirmity, emotional or psychological trauma, or bacterial or viral infection, or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
2. Suicide, self-destruction, attempted suicide or self-destruction, or intentional self-inflicted injury, while sane or insane;
3. War or any act of war, whether declared or not;
4. Commission of, or attempt to commit, a felony, an assault, or other illegal activity;
5. The covered person being legally intoxicated as determined according to the laws of the jurisdiction in which the injury occurred
6. The covered person being intoxicated or under the influence of any drugs or narcotics unless administered by or upon the advice of a physician.
7. Any loss arising out of terrorism or terrorist acts.
8. Injury covered by workers' compensation, employer's liability laws, or similar occupational benefits, or while engaging in activity for monetary gain from sources other than the Policyholder;
9. A covered accident that occurs while on active duty service in the military, naval or air force of any country or international organization. Upon our receipt of proof of service, we will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded, unless it extends beyond 31 days;
10. Travel in any aircraft owned, leased, or controlled by the Policyholder, or any of its subsidiaries or affiliates. An aircraft will be deemed to be "controlled" by the Policyholder if the aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year;
11. Practice or play in any sports activity, including travel to and from the activity and practice, except as specifically provided in the policy;
12. Aggravation, during a covered activity, of an injury the covered person suffered before participating in that covered activity, unless we receive a written medical release from the covered person's physician;
13. Participation in covered activities not sponsored by or under the supervision of the Policyholder.
14. The covered person riding or driving in any kind of race.

- **Accident Medical Exclusions:** In addition to the General Exclusions stated in the Policy, We will not cover expenses under this additional benefit for:

1. Pre-existing conditions occurring within the first 12 months of coverage (except as specifically provided by the policy);
2. Treatment by persons employed or retained by a Policyholder, or by any immediate family member or member of the covered person's household;
3. Pregnancy, childbirth, or miscarriage;
4. Elective abortion, an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed;
5. Mental and nervous disorders (except as specifically provided in the policy);
6. Damage to or loss of dentures or bridges, or damage to existing orthodontic equipment (except as specifically covered by the policy);
7. Elective or cosmetic surgery, except for reconstructive surgery needed as the result of an injury;
8. Eyeglasses, contact lenses, hearing aids, wheelchairs, braces, appliances, examinations or prescriptions for them, or repair or replacement of artificial limbs, orthopedic braces, or orthotic devices (except as specifically provided in the policy;
9. Expenses for which the covered person would not be responsible for in the absence of this policy;
10. Treatment of injuries that result over a period of time (such as blisters, tennis elbow, etc.), and that are a normal, foreseeable result of participation in the covered activity;
11. Treatment or service provided by a private duty nurse (except as specifically provided in the policy);
12. Replacement of artificial limbs, eyes, or other prosthetic appliances;
13. Routine physicals, check-ups, routine ob-gyn visits, pap smears, or wellness visits;
14. Overuse symptoms including, but not limited to, bursitis, tendonitis, shin splints, stress fractures, heat exhaustion, heat stroke, heat prostration, malfunctions of the heart, embolism, reinjures or the aggravation thereof, sprains, hernia, strains, muscle tears, or repetitive motion injury, except as specifically provided in the policy;
15. Expenses due to an aggravation or re-injury of a pre-existing condition (except as specifically provided in the policy);
16. Repair or replacement of existing dentures, partial dentures, braces, fixed or removable bridges, or other artificial dental restoration (except as specifically provided in the policy);
17. Repair, replacement, examinations for prescriptions, or the fitting of eyeglasses or contact lenses;
18. Medical expenses and disability for which the covered person is entitled to benefits under any Worker's Compensation Act;
19. Expenses incurred that are in excess of reasonable charges, or expenses that are not medically necessary; or
20. Dental treatment necessitated by sickness, deterioration or disease, for cosmetic, preventive, diagnostic or orthodontic purposes, or by any reason other than an injury.

- **Definitions**
  Accident means a sudden, abrupt, and unexpected event. **Covered Accident** means an accident that occurs directly and independently of all other causes while coverage is in effect for a covered person resulting in a covered loss or injury under the policy for which benefits are payable. **Contributory** means the Insured is required to pay all or a portion of the premium. Whether the benefits are Contributory or Non-Contributory is stated in the Schedule. **Covered Activity** means those activities set out in the Covered Activities section of the schedule of benefits, with respect to which covered persons are provided accident insurance under the policy. **Covered Loss** or **Covered Losses** means an accidental death, dismemberment or other injury covered under the policy. **Covered Person** means an eligible person, who enrolls for coverage, if required, and for whom the required premium is paid. **Eligible Person** means a person in a Class of Eligible Persons, as shown in the schedule of benefits. **Injury** means bodily injury sustained by a covered person caused by a covered accident that:
  1. Occurs while this policy is in effect as to the person whose injury is the basis of claim;
  2. Occurs while the covered person is participating in a covered activity; and
  3. Results directly and independently of all other causes in a covered loss.

  Physician means a provider or practitioner who:
  1. Is properly licensed or certified to provide care or treatment under the laws of the state where he or she practices;
  2. Provides services that are within the scope of his or her license or certificate; and
  3. Is neither the covered person nor a member of the covered person's household or an immediate family member.

  Schedule of Benefits means the benefits, benefit amounts, terms, limitations and provisions of coverage selected by the Policyholder which is attached to and made a part of this policy. **Spouse** means an adult person with whom the covered person enters into a marriage, civil union, or comparable relationship in a state or nation in which the marriage, civil union or comparable relationship is sanctioned by law and legally valid at the time it is entered into by the parties. **Policy** means the contract issued by us to the Policyholder for the benefit of a covered person.

ACTIVITES	DATE BEGINS	TO DATE ENDS	ESTIMATED # OF PARTICIPANTS	AGES FROM-TO

Any person who, with the 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.

GAA-2202Ed.11-16 (NC)(OH)

E-9712SR

EXCLUSIONS

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 Worker's Compensation or Employer's Liability Laws. (In NC, benefits are excluded if the employer, employee 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, an insured person must be participating as a professional)
4. In Ohio - Reinjury if the insured participated in a covered activity against medical advice

TO FILE A CLAIM

1. The Policyholder **must** complete Part A of the claim form for all accidents. The parent/guardian or insured must complete **all** questions in Part B or Part C of the claim form.
2. The parent/guardian or insured must:
   a) Obtain copies of the insured's **itemized bills**. The bills must contain the procedure codes, diagnosis codes, and tax ID and NPI numbers of the provider. Do not submit monthly balance due statements.
   b) Submit the insured's itemized bills to the family medical or dental coverage first. This plan is designed to be supplemental to all other valid coverage. The other insurance plan will send a report called Explanation of Benefits (EOB).
   c) Send the completed claim form, copies of insured's itemized bills and EOBs to:

STUDENT ASSURANCE SERVICES, INC.
PO BOX 196
STILLWATER MN 55082-0196
(For 2. b and c above, coverage is primary in ID, SD)

For claim questions contact Student Assurance Services at (800) 328-2739 or (651) 439-7098 between 8:00 am and 4:30 pm Central standard time, Monday thru Friday.

TO APPLY FOR COVERAGE

1. Complete and return the attached application, with the estimated number of participants and the premium amount. The premium payment must be returned with the application.
2. The Master Policy and company claim form will be sent to the Policyholder.
3. Make checks payable and mail to:

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

PREMIUMS

See Agent Proposal

Policy GA-2200Ed.11-16 (ID)(LA)(MN)
(MT)(NC)(ND)(OH)(SD)(TX)(UT)

ACCIDENT INSURANCE

for

Special Risk Programs
Sport Camps
Amateur Sports Programs
Rec & Park Programs

ADMINISTERED BY

STUDENT ASSURANCE SERVICES INCORPORATED

Stillwater, Minnesota

UNDERWRITTEN BY

Ameritas

Ameritas Life Insurance Corp.
Lincoln, Nebraska

E-9712SR (SR)

Accident Insurance for Special Risk

STUDENT ASSURANCE SERVICES
E-9712SR (SR)

COVERAGE OPTIONS

This insurance plan provides benefits for covered medical expenses resulting from bodily injury caused directly by accident, independent of all other causes, sustained while the participant is:

a) practicing, playing, or participating in a special risk activity while under the supervision of a Policyholder's employee; and
b) traveling to or from such special risk activity while under the supervision of a Policyholder's employee.

The Policy provides a maximum benefit up to $25,000 per injury and covers all special risk activities sponsored and supervised by the Policyholder.

All participants must purchase coverage. (In OH, a participant is a student)

The Medical Benefits and Exclusions apply to Coverage Options above.

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 Policyholder as stated on the application. A copy of the Privacy Notice and Certificate of Coverage (where applicable) will be sent to the policyholder.

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 charges (U&C) incurred for covered services below, for expenses incurred within one year from the date of injury up to a **maximum benefit of $25,000 per injury.**

This insurance plan is secondary to all other valid coverage. A claim must be filed with other valid coverage first! (This coverage is primary in ID, SD) This plan does not cover penalties imposed for failure to use providers preferred or designated by the primary coverage. (In NC, other valid coverage does not include automobile or liability coverage)

Unless stated otherwise, amounts listed below are per injury.

PHYSICIAN'S SERVICES
a) **Surgical Care** (surgeon, assistant surgeon, anesthesia).....U&C, up to $2,500
b) **Nonsurgical Care** (includes physiotherapy treatment performed other than in a hospital, 1 visit per day) .....U&C, up to $100 per visit, maximum 10 visits

HOSPITAL CARE
a) **Inpatient Care**
1) **Hospital Semi-Private Room** .....U&C, up to $700 per day
2) **Hospital Miscellaneous Services**.....U&C, up to $1,000

b) **Outpatient Care**
1) **Facility Charges for Day Surgery** .....U&C, up to $1,000
2) **Emergency Room** .....U&C , for hospital miscellaneous charges incurred, up to $1,000

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 $300

DIAGNOSTIC IMAGING (MRI, CT Scan, bone scan, includes 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 $200 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 $200

PRESCRIPTION DRUGS (take home)..... U&C, up to $250

REPLACEMENT OF EYEGLASSES, CONTACT LENSES, HEARING AIDS (when medical treatment is required for a covered injury)..... U&C up to $500

MOTOR VEHICLE INJURY ..... Same as any injury, up to $2,500

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

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.(In OH, this provision does not apply)

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.

APPLICATION FOR SPECIAL RISK ACCIDENT INSURANCE

Ameritas
Ameritas Life Insurance Corp.
Lincoln, Nebraska

Name of Policyholder _____
Street Address _____ City _____ State _____ Zip _____
List the Activities for which this application applies on the back of this form. Effective Date _____ Expiration Date _____
Does NOT include coverage for Contact Football - Please contact agent for special rate
Number of Participants _____ X $3.00 * = _____ Total Premium Enclosed $ _____ (Minimum Premium $300.00)
(*Rate per insured) (Sub Total)
Applied for by: Name(please print) _____ Title _____
e-mail address _____ Phone _____
Signature _____ Date _____
I certify the information recorded on this application is the information provided by the Applicant.
Agent _____
Print Name Phone Number E-Mail Address
Agent Mailing Address

*The maximum term of coverage at this premium rate is 3 months. If longer term of coverage is needed, please contact our office for rates.

PLEASE SEND APPLICATION AND PREMIUM PAYMENT TO:
Student Assurance Services, Inc., PO Box 196, Stillwater, MN 55082-0196 Phone Toll Free (800) 328-2739

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