Student Accident Insurance

Comprehensive Group - $250 Per Injury Deductible Plan
Policy GA-2200Ed.11-16

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. practicing or competing in school-sponsored and supervised interscholastic sports, and
d. traveling directly to and from school for regular school session; and while traveling to and from school sponsored and supervised extracurricular activities or interscholastic sports in school-provided transportation.

OTHER COVERAGE OPTION TO PURCHASE

PARENTS: Now you may extend this valuable school-time protection by purchasing 24-Hour Accident coverage:
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.

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 option 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 benefit of **$25,000 per injury, less a $250 deductible per Injury** (deductible is subtracted from covered expenses). Unless stated otherwise, all amounts listed below are per injury.
This insurance plan is secondary to all other valid coverage. A claim must be filed with other valid coverage first! This plan does not cover penalties imposed for failure to use providers preferred or designated by the primary coverage.

PHYSICIAN'S SERVICES
a) **Surgical Care**
- **Surgeon** - U&C; only one procedure will be allowed (the highest scheduled) when multiple procedures are performed through the same incision or in immediate succession
- **Assistant Surgeon and Anesthesia Services** - 25% of the surgeon's allowance

b) **Nonsurgical Care** (includes physiotherapy, 1 visit per day; other than concussion) - U&C, up to $100 per visit, maximum 10 visits
c) **Nonsurgical Care for Concussion** (treatment for concussion) - U&C, up to $1,000

HOSPITAL CARE
a) **Inpatient Care**
- **Hospital Semi-private Room** - U&C
- **Hospital Miscellaneous Services** (includes charges for registered nurse) - U&C

b) **Outpatient Care**
- **Facility Charges for Day Surgery and Emergency Room** (does not include physiotherapy) - U&C
- **Physiotherapy** - U&C, up to $1,000

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) - U&C
DENTAL TREATMENT (in lieu of all other medical benefits, for sound and natural teeth) - U&C, up to $5,000
AMBULANCE SERVICES (benefit for ground ambulance only) - U&C
ORTHOPEDIC APPLIANCES (when prescribed by a physician for healing; includes charges for durable medical equipment) - U&C, up to $300
PRESCRIPTION DRUGS (take home) - U&C, up to $300
REPLACEMENT EYEGLASSES, CONTACT LENSES, HEARING AIDS (when medical treatment is required for covered injury) - U&C, up to $300
LABORATORY SERVICES (Outpatient) - U&C, up to $300
SHOTS AND INJECTIONS (Outpatient, in lieu of physician non-surgical care) - U&C, up to $300
MOTOR VEHICLE INJURY - Same as any Injury, up to $2,000

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.

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 Single Dismemberment.....$2,500 Double Dismemberment.....$10,000

J-5682(2024) (12D250)

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

IS YOUR CHILD PROTECTED?

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.

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 authorized interscholastic sports practice; 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. Interscholastic Sports coverage will expire on the last day of the authorized season 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 applicable endorsements. 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 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

J-5682(2024) (12D250)

Enrollment Form for Student Accident Insurance

Ameritas

Ameritas Life Insurance Corp.
Lincoln, Nebraska

❑ **24-HOUR COVERAGE $95**

One time policy year premium. 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*** J-5682(2024)(12D250)

PROOF OF CLAIM

There is a timely filing period of one year and ninety days. Do not wait to send information as this may result in claim denial.

Email, Fax or Mail completed form to:
STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MINNESOTA 55082

NOTICE: Anyone who knowingly misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment.

CLAIM PROCEDURE:

1. A school official must complete and sign PART A*.
2. The student's parent or guardian must complete PART B.
3. See Page 2 for important claim procedures.

TO BE COMPLETED BY A SCHOOL OFFICIAL

PART A: NOTICE OF INJURY

1. Name of School _____ School District Name _____
   School Address _____ (City) (State) (Zip)
2. Name of Student _____ Grade _____
3. Date of Injury _____ ☐ AM ☐ PM
4. Under whose supervision? _____ Was he/she a witness? _____
5. The accident was incurred while the Insured was participating in:

INTERSCHOLASTIC SPORTS

☐ Practice ☐ Travel to/from Sport
☐ Game
What Sport? _____

NON-INTERSCHOLASTIC SPORTS

☐ Travel to/from School ☐ Non-school activity
☐ In classroom ☐ Physical Education
☐ Other - Activity _____
☐ On school grounds

6. Part of the body injured _____ ☐ Left ☐ Right
7. Describe in detail how and where the injury occurred _____

_____

_____

_____

Reported by _____ (Signature of School Official) (Title) Date(mm/dd/yyyy)

(*Part A may be completed by the parent if Full-Time Coverage was purchased.)
IMPORTANT INFORMATION ON Page 2

TO BE COMPLETED BY A PARENT OR GUARDIAN

PART B: PARENT STATEMENT

1. Students Name _____ Date of Birth _____ Date (mm/dd/yyyy)

   Students Social Security # _____ - _____ - _____

   Parents Name _____ Relationship to Insured _____

   Mailing Address _____ (Street, Route, Box, Apt., or Lot #) (City) (State) (Zip)
2. Home phone number _____
3. Father's Occupation _____ Employer _____

   Mother's Occupation _____ Employer _____
4. Do you have insurance coverage? ☐ Yes ☐ No Is the student covered under your insurance plan? ☐ Yes ☐ No

   Name of Insurance Company _____

   ☐ Group ☐ Individual ☐ Medicaid ☐ CHIP ☐ Tricare ☐ None

I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, or other organization, institution, or person that has any records or knowledge of the claimant's physical or mental health, to give the information to STUDENT ASSURANCE SERVICES, INC. To facilitate rapid submission of such information, I authorize all said sources, to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information. A photocopy of this authorization shall be as valid as the original. This authorization expires one year from the date signed. By entering my name below, I am indicating my intent to sign this claim form and warrant that all of the information provided is true, complete, and accurate.

_____ Date (mm/dd/yyyy) _____ (Print Name of Student/Patient) _____ (Signature of Parent or Guardian)

TO PARENT OR GUARDIAN:

STEPS TO FOLLOW WHEN FILING A CLAIM:

1. Only one Student Assurance Services, Inc. (SAS) completed claim form for each accident needs to be submitted. Students must be treated by licensed physician or facility within the required time as stated in the policy.

2. The claim form and benefit summary are available at SAS website: **www.sas-mn.com**. However, using this form is not a guarantee of benefits or confirmation of coverage under the plan. Benefits and eligibility will be evaluated when the claim is submitted, subject to all applicable terms, conditions, limitations and exclusions of the plan.

3. A school official **must** complete Part A of the claim form for all school related accidents. The parent or guardian must complete Part B – Parent Statement of the claim form. Answer all questions on the claim form. If the accident is not school related, the parent or guardian **may** complete both Part A and Part B.

4. Submit copies of the student's **itemized bills** with the completed claim form. **Balance due statements cannot be processed.** These itemized bills often called UB-04 or CMS-1500 provide the Address, Date of Service, Procedure Code, Diagnosis Code, Federal Tax ID Number and NPI number of the treating physician or facility. **This plan has a timely filing deadline, do not wait to send information.**

   Note: A copy of the claim form can be given to the treating physician or facility. The provider may submit UB-04 or CMS-1500 itemized bills directly to SAS on the student's behalf. However, do NOT depend on the provider to submit the claim form or itemized bills to SAS. It is the parent/guardian's responsibility to provide this information.

5. **Submit copies of the itemized bills to the student's primary family and/or group insurance company first**, even if the other insurance plan has a large deductible or copay. This plan pays second or is supplemental to all other valid coverage (does not apply to SAS primary plans). This plan does not cover penalties imposed for failure to use providers preferred or designated by the other primary insurance plan. The other insurance plan will provide an Explanation of Benefits (EOB) showing payment, write-off, deductible, copay, and coinsurance.

6. Mail, fax, or email the completed claim form, student's itemized bills and other insurance EOBs to:

STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MN 55082-0196
Fax: (651) 439-0200
Email: claims@sas-mn.com
Phone Number: 1-800-328-2739

NO CLAIM CAN BE PROCESSED UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN PROVIDED TO SAS:

1. **Completed Claim Form**
2. **Itemized Bills (UB-04 or CMS-1500)**
3. **Explanation of Benefits (EOB) from the primary insurance plan**
4. **FOR DENTAL CLAIMS - American Dental Association Standardized itemized billing form**

PLEASE REFER TO THE MASTER POLICY ISSUED TO THE SCHOOL/SCHOOL DISTRICT FOR SPECIFIC DETAILS.