

Student Accident Insurance

Premier Group - \$250 Deductible Plan

Policy Form GH-2200

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 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 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--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. Coverage becomes effective when the premium is received by the Company.

HOW TO ENROLL: Complete the attached enrollment form, enclose with your check and mail to: (DO NOT SEND TO SCHOOL)

Student Assurance Services, Inc. P.O. Box 196, Stillwater, MN 55082

The Medical Benefits and Exclusions 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 necessary services and supplies as listed below, for expenses actually incurred within one year from the date of injury up to a maximum 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) for surgical operations (Surgeon, Assistant Surgeon, Anesthesia) - 100% U&C charges incurred. 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 are payable at 25% of the surgery allowance.
- b) for nonsurgical care (including Physiotherapy) - 100% U&C charges incurred.

HOSPITAL CARE

- a) **Inpatient Care** - the usual daily charges incurred for the hospital's most common semi-private room rate, plus 100% U&C miscellaneous charges incurred. Benefits for miscellaneous charges are limited to services not scheduled under Medical Benefits.
- b) **Outpatient Care** (includes Day Surgery Facility and Emergency Room) - 100% U&C miscellaneous charges incurred (not including Physiotherapy). Benefits for miscellaneous are limited to services not scheduled under Medical Benefits. Physiotherapy - 100% U&C charges incurred, up to \$1,000.

RADIOLOGY SERVICES (includes x-ray, MRI, CT Scan, bone scan, and charges for reading) - 100% U&C charges incurred.

HEAD INJURY (outpatient benefit for the treatment of concussion only) - Same as any Injury, up to \$2,000.

DENTAL TREATMENT (in lieu of all other medical benefits) - 100% U&C, up to \$5,000.

AMBULANCE SERVICES (benefit for ground ambulance only) - 100% U&C charges incurred.

ORTHOPEDIC APPLIANCES (when prescribed by a physician for healing) - 100% U&C charges incurred, up to \$200.

PRESCRIPTION DRUGS (take home) - 100% U&C charges incurred, up to \$25.

MOTOR VEHICLE INJURY - Same as any Injury, up to \$1,000.

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 \$2,000 Single Dismemberment \$2,000 Double Dismemberment \$10,000

Y-5672(2013)

(12D-A250)

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 Worker' 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, eyeglasses, hearing aids or prescriptions or examinations thereof.

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 will fill out Part A if it's a school injury.
2. Parents complete Part B. Answer all questions.
3. Parents submit copies of your itemized bills to your family medical or dental coverage first, even if you have a large deductible. You will be sent a report called an Explanation of Benefits (EOB).

4. Parents send the claim form, copies of itemized bills and the EOB to:
STUDENT ASSURANCE SERVICE, INC.
PO BOX 196
STILLWATER MN 55082
5. The claim will be completed when all of the above documents have been provided. Should you have a question as to the status of a claim, you can contact Student Assurance Services, Inc. at 1-800-328-2739.

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 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 school 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 GH-2200 (and any state specific). 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.



Underwritten by

SECURITYLIFE
INSURANCE COMPANY OF AMERICA
MINNETONKA, MINNESOTA



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

Y-5672(2013)

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Enrollment Form for Student Accident Insurance

Underwritten by: **SECURITYLIFE**
INSURANCE COMPANY OF AMERICA
MINNETONKA, MINNESOTA

24-HOUR COVERAGE \$85

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 _____

GHA-2202(GEN)

Attach Premium Check - NO REFUNDS - Premium cannot be prorated

Y-5672(12D-A250)(2013)