

# Summary of Coverage

## This is a Limited Benefit Policy. Accident Only Insurance. Non-Renewable

The school is participating in a medical insurance Plan that would provide benefits for accidental bodily injury incurred while:

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| <p>a. attending regular school sessions,</p> <p>b. participating in or attending school-sponsored and supervised extracurricular activities,</p> <p>c. participating in school-sponsored and supervised interscholastic sports, and</p> | <p>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.</p> |
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**THIS PLAN IS SECONDARY TO ALL OTHER VALID COVERAGE. A CLAIM MUST BE FILED WITH YOUR OTHER COVERAGE FIRST! THE INSURANCE PLAN DOES NOT COVER PENALTIES IMPOSED FOR FAILURE TO USE PROVIDERS PREFERRED OR DESIGNATED BY YOUR PRIMARY COVERAGE.**

**OFFERED MEDICAL PAYMENTS (up to \$25,000)**

When accidental bodily 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 for Medical Services which are received within one year from the date of Accident up to the specified Maximum Medical Benefit.

### SCHEDULE OF COVERED SERVICES

Maximum (School-Time) .....	\$25,000
Maximum (Interscholastic Sports) .....	\$25,000
Excess Coverage .....	Yes
<b>1. INPATIENT BENEFITS</b>	
a. Hospital Room and Board (R&B) .....	Semi-private room charges up to \$300 per day
b. Hospital Miscellaneous Services (All Charges except R&B) .....	up to \$1,500 per injury
c. Physician's Non-Surgical Visits (other than Physical Therapy) .....	up to \$25 per visit, maximum of 10 visits
d. Physical Therapy Treatment (includes whirlpool, diathermy, EMS, massage, manipulation or adjustments in any form, and/or office visits connected therewith) .....	included in Hospital Miscellaneous Services
e. X-rays and related services (including charges for reading) .....	included in Hospital Miscellaneous Services
<b>2. OUTPATIENT SURGERY BENEFITS</b>	
a. Day Surgery (Facility Charge - includes room supplies and all other expenses for outpatient surgery) .....	up to \$1,000 per injury
<b>3. OTHER OUTPATIENT BENEFITS</b>	
a. Hospital Emergency Room Charges .....	up to \$300 per injury
b. X-rays and Radiology Services (including charges for reading) .....	up to \$150 per injury
c. Diagnostic Imaging (including charges for reading - MRI, CAT SCAN, Bone Scan) .....	up to \$200 per injury
d. Physician's Non-Surgical Visits (other than Physical Therapy) .....	up to \$25 per visit, maximum of 10 visits
e. Physical Therapy Treatment (includes whirlpool, diathermy, EMS, massage, manipulation or adjustments in any form, and/or office visits connected therewith) .....	up to \$30 per visit, max 10 visits
f. Orthopedic Appliances (when prescribed by a physician for healing) .....	up to \$100 per injury
g. Prescription Drugs .....	up to \$25 per injury
h. Ambulance Service .....	up to \$200
i. Outpatient Lab Services .....	up to \$50 per injury
<b>4. OTHER PHYSICIAN SERVICES</b>	
a. Dental Treatment (in lieu of all other Medical Benefits; including X-rays of sound & natural teeth) .....	up to \$100 per tooth
b. Physician Surgical Care (Inpatient or Outpatient; includes pre-operative and post-operative care, limited to the primary procedure per surgery) .....	50% of U&C Charges
c. Assistant Surgeon Charges (Inpatient or Outpatient) .....	20% of Surgeon's Allowance
d. Anesthesia Charges (Inpatient or Outpatient) .....	20% of Surgeon's Allowance
<b>5. MISCELLANEOUS SUPPLIES, SERVICES, LIMITATIONS</b>	
a. Motor Vehicle Injury (subject to covered services limits) .....	up to \$500 per injury
b. Eyeglasses Replacement (when medical treatment is required for a covered injury) .....	up to \$75 per injury

### ACCIDENTAL DEATH and DISMEMBERMENT

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

Loss of Life	\$3,000	Double Dismemberment	\$12,000
Loss of an Eye	\$3,000	Single Dismemberment	\$ 3,000

### EXCLUSIONS - The policy does not provide benefits for:

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| <p>1. Any sickness, disease, infection (unless caused by an open cut or wound), 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, injuries involving bone cysts or dental implants. For Policies issued in West Virginia - Hernia of any kind unless caused by an accident.</p> <p>2. Injuries for which benefits are payable under Workers' Compensation or Employer's Liability Laws.</p> <p>3. The services of a second or subsequent Physician when not requested in writing by the attending Physician. This exclusion does not apply to any Assistant Surgeon Benefits.</p> <p>4. 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</p> | <p>and highways, unless the insured is participating in an activity sponsored by the Policyholder.</p> <p>5. Air travel or the use of any device or equipment for aerial navigation, except as a fare-paying passenger on a regularly scheduled commercial airline.</p> <p>6. Intentionally self-inflicted Injuries; Injuries sustained while fighting or brawling, or violating or attempting to violate any existing city, state, or federal law; Injuries resulting from the use of alcohol, drugs or narcotics, unless administered on the advice of physician.</p> <p>7. Treatment received from any person employed or retained by the Policyholder.</p> <p>8. Replacement of contact lenses, hearing aids or prescriptions or examinations thereof.</p> <p>9. Durable medical equipment.</p> |
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Policy Form No. GH-211(rev.)

T-5918 (OH-WV)

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



IS YOUR CHILD PROTECTED?

## 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. Dental accidents are often covered by health insurance, please submit charges for all dental accidents to your family health insurance first.
4. Parents submit copies of your itemized bills to your own family insurance first, even if you have a large deductible. You will be sent a report called an Explanation of Benefits (EOB).

5. Parents send the claim form, copies of itemized bills and the EOB to:  
 STUDENT ASSURANCE SERVICE, INC.  
 PO BOX 196  
 STILLWATER MN 55082
6. 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.

THIS BROCHURE IS A SUMMARY OF THE MASTER INSURANCE POLICY ISSUED TO AN EDUCATIONAL INSTITUTION. IF THERE IS A DISCREPANCY BETWEEN THIS BROCHURE AND THE MASTER POLICY, THE MASTER POLICY LANGUAGE WILL GOVERN.

**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.

### Administered by

**STUDENT ASSURANCE SERVICES, INC.**  
 PO BOX 196  
 STILLWATER, MN 55082  
 (800) 328-2739 - (651) 439-7098

### Underwritten by

**SECURITY LIFE INSURANCE  
 COMPANY OF AMERICA  
 MINNETONKA, MN**

## PARENTS: Now you may extend this valuable school-time protection. You have two options:

- A) **FULL-TIME COVERAGE**--provides benefits for doctor, hospital and dental expenses (same as explained on the reverse side of form) and covers your child 24 hours a day, any time, anywhere until school starts next year.
- B) **DENTAL ACCIDENT COVERAGE** Provides up to \$5,000 in benefits for any dental accident. Covers the student 24 hours a day until school starts next year. Treatment must begin within 60 days from the date of injury. Benefits are limited to expenses actually incurred within one year from the date of accident. However, if within the one year period following the date of accident the insured's attending dentist certifies that dental treatment and/or replacement must be deferred beyond one year, the plan will pay the estimated cost of such deferred treatment, but not to exceed \$200 for each tooth. No benefits will be allowed for orthodontics or dental disease and benefits for prosthesis are limited to \$500 per injury, including procedures performed to install them. Dental prosthesis includes, but is not limited to: crowns, caps, bridges, and implants. Endorsement GHR-181(95)

### HOW TO ENROLL:

1. Complete the attached Enrollment Form below, and enclose your check and mail to: STUDENT ASSURANCE SERVICES, INC., P.O. BOX 196, STILLWATER, MN 55082-0196. (DO NOT SEND TO THE SCHOOL). Please write the name of the student on your check.
2. Be sure to retain this brochure. You will not receive a policy. The Master Policy is issued to your school.

### Effective and Expiration Date:

Coverage becomes effective on the later of: the date the premium is received by the Company or its authorized agent; or the Master Policy Effective Date. Coverage for Full-Time and Extended Dental expires on the earliest of: first day of school next year; or the Master Policy Expiration Date.

For specific costs and further details of the coverage, including exclusions, reductions or limitations, contact or write the Plan Administrator.

AVAILABLE FOR USE IN: OH-WV

T-5918 (OH-WV)

## 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)

School \_\_\_\_\_ Dist \_\_\_\_\_  
 Student's Age \_\_\_\_\_ Grade \_\_\_\_\_ Phone \_\_\_\_\_

X \_\_\_\_\_  
 (Signature of Parent or Guardian) (Date)

### Select Option and Coverage(s) Below

#### ACCIDENT PLAN PREMIUMS

- |                                       |                                   |
|---------------------------------------|-----------------------------------|
| FULL-TIME COVERAGE (24-Hours)         | <input type="checkbox"/> \$ 85.00 |
| DENTAL ACCIDENT COVERAGE (24-Hours)   | <input type="checkbox"/> \$ 7.00  |
| FULL-TIME & DENTAL ACCIDENT COVERAGES | <input type="checkbox"/> \$ 92.00 |

**TOTAL PREMIUM \$**

Make Checks payable and mail to: **STUDENT ASSURANCE SERVICES, INC. PO BOX 196, STILLWATER, MN 55082-0196.**  
 Please write student's name on the front of check. **NO REFUNDS, except as provided in the Master Policy. DO NOT SEND CASH.**  
**OH Only:** Any person who, with 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.

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