2023-2024 CERTIFICATE OF COVERAGE

Policy Form GA-2200(KS)Ed. 11-16

Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA

STUDENT BLANKET ACCIDENT INSURANCE

NON-RENEWABLE- THIS IS A LIMITED BENEFIT POLICY

IN FORCE COVERAGE - Each Insured is eligible for the in force coverage described below, subject to receipt of the premium and the terms, conditions, limitations, exclusions of the Policy:

SPECIAL RISK ACTIVITY – Coverage is in force for each Insured for whom the required premium has been paid as set forth in this policy while participating in a CYO Activity for students in grades PK-12, which is Sponsored and Supervised by the Policyholder and is under the direct supervision of the Policyholder or an employee of the Policyholder. Includes traveling directly to and from such activity in a vehicle provided by the Policyholder and under the direct supervision of the Policyholder or an employee of the Policyholder.

BENEFITS FOR MEDICAL EXPENSES

When injury covered by this Policy results in treatment by a Licensed Physician within sixty (60) days from the date of Accident, the Company shall pay the Usual and Customary Charges (U&C) incurred for necessary Covered Services, subject to all terms, conditions, limitations and exclusions of this Policy. Benefits shall be payable for Expenses Incurred within one year from the date of Injury. The Company shall pay the scheduled benefit below for Covered Services up to the specified Maximum Medical Benefit of **$10,000 per Injury**.

The Company's liability for benefits payable on account of expense incurred, for any hospitalization, medical, surgical, and other services resulting from covered Injury of the covered person, shall be limited to that part of the expense, if any, which is in excess of the total benefits payable for the same loss, on a provision of service basis or on an expense incurred basis under any medical or service contract, self-funded plan, automobile medical payment coverage, or any plan under federal, state or local law (except Medicaid). If one or more of the other policies, plans or service contracts provides benefits on an excess insurance or an excess coverage basis, benefits should be paid first by the company or service plan whose policy or service contract has been in effect for the longer period of time at the date of such loss.

SCHEDULE OF COVERED SERVICES

(unless otherwise stated all amounts are per Injury)

1. **Physician's Services** (does not include physiotherapy)
   a) **Surgical Care** (includes services for surgeon, assistant surgeon, anesthesia) – U&C, up to $3,500
   b) **Non-Surgical Care** – U&C, up to $60 per visit, maximum 10 visits
2. **Hospital Care**
   a) **Inpatient Care**
      - Hospital Semi-private Room - U&C, up to $500 per day
      - Hospital Miscellaneous Services (includes charges for registered nurse) - U&C, up to $5,000
   b) **Outpatient Care** (includes facility charges for day surgery and emergency room) – 80% U&C, up to $3,500

   NOTE: Benefits for hospital miscellaneous and outpatient care charges are limited to services not scheduled under Covered Services.
3. **Radiology Services** (includes diagnostic imaging, x-rays and charges for reading) – U&C, up to $750
4. **Dental Treatment** (for repair and/or replacement of each sound and natural tooth, includes x-rays, in lieu of all other medical benefits) – U&C, up to $300 per tooth
5. **Ambulance Services** – U&C, up to $500
6. **Prescription Drugs** (take home) – U&C, up to $300
7. **Motor Vehicle Injury** – Same as any Injury
8. **Orthopedic Appliance** (when prescribed by a physician for healing; includes charges for durable medical equipment) – U&C, up to $300
9. **Eyeglasses. Contact Lenses and Hearing Aids** (replacement when broken as the result of covered injury when medical treatment is required) – U&C, up to $300
10. **Physiotherapy** (includes office visit) - U&C, up to $60 per visit, maximum 5 visits
11. **Laboratory Services** (Outpatient) – U&C, up to $300
12. **Shots and Injections** (Outpatient, in lieu of physician's non-surgical care) – U&C, up to $300

EXCLUSIONS

This Policy does not provide benefits for expenses resulting from:

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. Treatment for re-Injury, EXCEPT when the Insured is treatment free for a period of 180 days prior to the Policy Effective Date.
5. The practice or play of KSHSAA interscholastic sports and activities including travel to or from such activity, practice, or play.
6. 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.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

When Injury covered by this Policy results in the following specific Losses within 180 days from the date of Accident, the Company shall pay the benefit amount below listed opposite to the specific Loss, and shall be in addition to any other benefits payable under this Policy for such Accident. If the Insured sustains more than one Loss as a result of one Accident, the Company shall pay only one amount, the largest to which the Insured is entitled. Loss of a Hand or Foot means loss by severance at or above the wrist or ankle joint. Loss of Sight must be entire and irrecoverable.

Loss of Life	$ 2,500
Loss of both Hands, both Feet or Sight of both Eyes	$10,000
Loss of one Hand, one Foot or Sight of one Eye	$ 2,500

DEFINITIONS

Accident - means an unexpected, external and sudden event that is independent of any other cause.

Anesthesia - Benefits are payable for the administration of anesthesia when performed by a Physician or Certified Registered Nurse Anesthetist.

Coinsurance – means the percentage of eligible expenses that are payable as Benefits by the Company. The percentage is shown in the Schedule of Covered Services.

Company - means Ameritas Life Insurance Corporation.

Covered Services - means the services and supplies which are 1) Medically Necessary, 2) prescribed or performed by a Physician or Hospital for treatment of an Injury, 3) not excluded by this Policy, and 4) listed or named in this Policy's Schedule of Covered Services.

Dental Treatment – means Dentist's fees for surgery, x-rays, and other necessary dental services as a result of Injury to a Sound and Natural Tooth.

Diagnostic Imaging - means the images of the body created using other forms of radiology that does not include x-ray radiographs (films), including but not limited to: computerized axial tomography (CT); magnetic resonance imaging (MRI); radionuclide imaging (nuclear medicine); bone scans; and ultrasound (US). Benefit includes the fees for interpretation or reading of imaging results and the administration of contrast material.

Durable Medical Equipment – means medical equipment or device which can be rented, leased or purchased and which 1) is prescribed by a Physician; 2) is primarily and customarily used to serve a medical purpose; 3) can withstand repeated use; 4) generally is not useful to a person in the absence of Injury; and 5) is used exclusively by the Insured. Replacement equipment and devices are not covered. No benefits will be paid for rental charges in excess of purchase price. Durable Medical Equipment does not include non-prescription therapy devices or medical supplies; comfort and convenience items; corrective shoes; exercise and sports equipment. A written prescription must accompany the claim when submitted.

Expense Incurred – means the charge made for a service, supply, or treatment that is a Covered Service under this Policy. The expense is considered to be incurred on the date the service or treatment is given or the supply is received.

Hospital - means an institution which 1) is licensed by the state (if required) or other laws of jurisdiction; 2) is operated for the medical care and treatment of injured persons on an inpatient basis; 3) provides 24-hour nursing services or supervised by a graduate registered nurse; 4) has medical, diagnostic and treatment facilities with major surgical facilities on its premises or available to it on prearranged basis; 5) has a staff of one or more Physicians available at all times. It is not primarily a clinic, sanitarium, nursing home, skilled nursing facility, rest home or used for custodial or educational care, or an institution that mainly provides treatment for mental illness or substance abuse.

Injury - means an accidental bodily Injury or injuries directly caused by specific accidental contact with another body or object while the Insured is covered under this Policy. It is unrelated to any pathological, functional, or structural disorder. The Accident must result in an Injury which begins while the Insured is covered under this Policy.

Inpatient – means confinement in a Hospital for at least eighteen (18) or more consecutive hours.

Medically Necessary – means a Covered Service which is: 1) consistent with symptoms and diagnosis or treatment of Injury; 2) in accordance with standards of generally accepted medical practice; 3) not primarily for the convenience of the patient or Physician; and 4) most appropriate supply or level of service which can be safely provided.

Orthopedic Appliances – means a supportive appliance or device designed specifically for use in the correction or prevention of human deformities, defects of the skeleton, joints, or spine and which: 1) is prescribed by a Physician; 2) is primarily and customarily used to serve a medical purpose; 3) can withstand repeated use; 4) generally is not useful to a person in the absence of Injury; and 5) is used exclusively by the Insured. Replacement braces and appliances are not covered. A written prescription must accompany the claim when submitted.

Physician - means a doctor of medicine or osteopathy, or any other licensed health care provider that state law requires to be recognized as a Physician, other than the Insured or Insured's relative by blood or marriage, who is acting within the scope of such license.

Physiotherapy - means any form of therapeutic or manual treatment provided by a Physician, including but not limited to: physical or mechanical therapy, diathermy, ultrasonic treatment, EMS, whirlpool, heat treatments or manipulation. Includes office visit connected with the physiotherapy.

Prescription Drug – means a drug which has been determined to be safe and effective by the Food and Drug Administration and which can, under federal or state law, only be dispensed when ordered by a Physician who is duly licensed to prescribe such medication.

Residence - means the building and grounds where the Insured lives.

Sound and Natural Tooth - means the major portion of the individual tooth, formed by the human body, is present. Does not include teeth that are carious, abscessed, or defective.

Sponsored and Supervised Activity - means any activity which is exclusively sponsored by the Policyholder and which is under the direct and immediate supervision of an employee of the Policyholder.

Surgical Care – means Physician's fees for surgery. Surgical procedures are identified in the Surgery section of the Physicians' Current Procedural Terminology (CPT). Unless otherwise defined in the Schedule of Covered Services, if two or more procedures are performed through the same incision or at the same operative session, the maximum amount payable for the subsequent procedure(s) will not exceed 50% of the Usual and Customary Charges for the subsequent procedure(s).

Usual and Customary Charges (U&C) - means charges for medical services or supplies for which the Insured is legally liable and which do not exceed the average rate charged for the same or similar services or supplies in the geographic region where the services or supplies are received. Usual and Customary Charges for Covered Services - Supplies are determined by referencing the 75th percentile of the most current survey published by Fair Health Inc. for such Covered Service.

X-ray Services - Covered Services includes x-ray and radiology examination, consultation and fees for interpretation or reading of X-rays and other radiology results. Diagnostic X-rays are obtained from an x-ray machine and images are recorded on radiographs (films). This benefit does not include Diagnostic Imaging if listed as a separate benefit in the Schedule of Covered Services.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES

This Policy, including the endorsements and attached papers, if any, and the Policyholder's application constitute the entire contract of insurance. All statements made by the Policyholder shall, in the absence of fraud, be deemed representations and not warranties. No such statements will be used in defense to a claim under this Policy unless it is contained in the written application signed by, and furnished to, the Policyholder. No changes in this Policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon and attached hereto. No agent has authority to change this Policy or to waive any of its provisions. The Insured or beneficiary can request a copy of the application by requesting one in writing. The Company will furnish a copy of the application within fifteen (15) days of the day the Company received the request.

NOTICE OF CLAIM

Written notice of claim must be given to the Company's Administrative Office within thirty (30) days after the occurrence or commencement of any loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given in behalf of the Insured or the beneficiary to the Company's Administrative Office, 333 North Main Street, Suite 300, Stillwater, MN 55082, or its authorized agent, with information sufficient to identify the Insured, shall be deemed notice to the Company.

CLAIM FORMS

The Company, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proofs covering the occurrence, the character and the extent of loss for which claim is made.

PROOFS OF LOSS

Written proof of loss must be furnished to The Company's Administrative Office, 333 North Main Street, Suite 300, Stillwater, MN 55082 within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

PAYMENT OF CLAIMS

All benefits under the policy shall be payable to the person insured, or to his designated beneficiary or beneficiaries, or to his estate, except that if the person insured be a minor, such benefits may be made payable to his parents, guardian, or other person actually supporting him. Unless the Company is requested otherwise in writing not later than the time of filing proofs of loss, such indemnities may be paid directly to the hospital or person rendering such services; but it is not required that the services be rendered by a particular hospital or person. Payment so made shall discharge the Company's liability with respect to the amount of insurance paid.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy and no such action shall be brought after the expiration of five (5) years after the time written proof of loss is required to be furnished in accordance with the requirements of this Policy.

ADDITIONAL POLICY PROVISIONS

EXCESS PROVISION

The Company's liability for benefits payable on account of expense incurred, for any hospitalization, medical, surgical, and other services resulting from covered Injury of the covered person, shall be limited to that part of the expense, if any, which is in excess of the total benefits payable for the same loss, on a provision of service basis or on an expense incurred basis under any medical or service contract, self-funded plan, automobile medical payment coverage, or any plan under federal, state or local law (except Medicaid). If one or more of the other policies, plans or service contracts provides benefits on an excess insurance or an excess coverage basis, benefits should be paid first by the company or service plan whose policy or service contract has been in effect for the longer period of time at the date of such loss.

EFFECTIVE DATE AND EXPIRATION DATE

Group coverage under this Policy with respect to each Insured shall become effective on the later of the following dates:

a) 12:01 a.m. following the date the application and premium payment is received by the Company's Administrative Office or its authorized agent; or
b) the Policy Effective Date, 08-01-2023.

Coverage under this Policy with respect to each Insured will end on the earliest of the following dates:

a) 11:59 p.m. on the date on which the Insured ceases to be enrolled in the School if the School-Time or Interscholastic sports and extracurricular activities coverage is purchased; or
b) 11:59 p.m. on the date on which the Insured ceases to be enrolled in the Special Risk activity; or
c) 11:59 p.m. on the last date of the period of coverage for which the premium was paid; or
d) 11:59 p.m. on the last date of the authorized season or activity for the Interscholastic Sports, Football or Special Risk Activity or other covered Activity of the current Policy period; or
e) 11:59 p.m. on the Policy Expiration Date, 07-31-2024.

PREMIUM

Special risk activities coverage requires 100% participation, the premium for group coverage is paid by Policyholder.

CLAIM PROCEDURE

Notify the Policyholder immediately when an Accident has occurred. Secure a claim form from the School, Servicing Agent, or from the Plan Administrator website, **www.sas-mn.com**. The Policyholder will complete Part A if it's a school injury. Parents or the student need to complete Part B of the claim form. Send the claim form and copies of all itemized doctor and hospital bills and other insurance explanation of benefits to:

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

Note: Proof of claim must be submitted to the address above within 90 days from the date of accident, or a reasonable time thereafter not to exceed one year. Itemized bills must be submitted within 90 days from the date of treatment or a reasonable time thereafter not to exceed one year. We are responsible only for expenses incurred within one year.

To check the status of your filed claim, questions regarding receipt of premium or verification of coverage may be answered by calling the Claims Office from 8:00 to 4:30 p.m. (Central Time), Monday – Friday or send an email. The toll free telephone number is 1-800-328-2739 or website is www.sas-mn.com.

Keep this certificate as your summary of coverage – no individual policy will be issued. A master policy is issued to the Policyholder. The master policy contains the contract provisions and shall prevail in the event of any conflict between this certificate and the master policy.

Privacy Notice:
You may obtain a copy of the Privacy Notice on the Student Assurance Services, Inc. website www.sas-mn.com.

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Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA

STUDENT BLANKET ACCIDENT INSURANCE

NON-RENEWABLE- THIS IS A LIMITED BENEFIT POLICY

IN FORCE COVERAGE

Each Insured is eligible for the in force coverage described below, subject to receipt of the premium and the terms, conditions, limitations, exclusions of the Policy.

SPECIAL RISK ACTIVITY – Coverage is in force for each Insured for whom the required premium has been paid as set forth in this policy, while participating in a CYO Activity which is Sponsored and Supervised by the Policyholder and is under the direct supervision of the Policyholder or an employee of the Policyholder. Includes traveling directly to and from such activity in a vehicle provided by the Policyholder and under the direct supervision of the Policyholder or an employee of the Policyholder.

BENEFITS FOR MEDICAL EXPENSES

When injury covered by this Policy results in treatment by a Licensed Physician within sixty (60) days from the date of Accident, the Company shall pay the Usual and Customary Charges (U&C) incurred for necessary Covered Services, subject to all terms, conditions, limitations and exclusions of this Policy. Benefits shall be payable for Expenses Incurred within one year from the date of Injury. The Company shall pay the scheduled benefit below for Covered Services up to the specified **Maximum Benefit of $25,000 per Injury, less a $10,000 deductible per Injury** (deductible is subtracted from covered expenses)**. The maximum benefit payable is $15,000 per Injury**.

The Company's liability for benefits payable on account of expense incurred, for any hospitalization, medical, surgical, and other services resulting from covered Injury of the covered person, shall be limited to that part of the expense, if any, which is in excess of the total benefits payable for the same loss, on a provision of service basis or on an expense incurred basis under any medical or service contract, self-funded plan, automobile medical payment coverage, or any plan under federal, state or local law (except Medicaid). If one or more of the other policies, plans or service contracts provides benefits on an excess insurance or an excess coverage basis, benefits should be paid first by the company or service plan whose policy or service contract has been in effect for the longer period of time at the date of such loss.

SCHEDULE OF COVERED SERVICES (unless otherwise stated all amounts are per Injury)

1. **Physician's Services** (does not include physiotherapy)
   a) **Surgical Care** (includes services for surgeon, assistant surgeon, anesthesia) – U&C
   b) **Non-Surgical Care** – U&C
2. **Hospital Care** (does not include physiotherapy)
   a) **Inpatient Care**
      - Hospital Semi-private Room - U&C
      - Hospital Miscellaneous Services - U&C
   b) **Outpatient Care** (includes facility charges for day surgery and emergency room) – U&C
3. **Radiology Services** (includes diagnostic imaging, x-rays and charges for reading) – U&C
4. **Dental Treatment** (for repair and/or replacement of each sound and natural tooth, includes x-rays, in lieu of all other medical benefits) – U&C
5. **Ambulance Services** – U&C
6. **Prescription Drugs** (take home) – U&C, up to $200
7. **Motor Vehicle Injury** – Same as any Injury
8. **Orthopedic Appliance** (when prescribed by a physician for healing; includes charges for durable medical equipment) – U&C
9. **Eyeglasses, Contact Lenses, and Hearing Aids** (replacement when broken as the result of covered injury when medical treatment is required) – U&C, up to $200
10. **Physiotherapy** (includes office visit) - U&C, up to $50 per visit, maximum 10 visits
11. **Laboratory Services** (Outpatient) – U&C, up to $300
12. **Shots and Injections** (Outpatient, in lieu of physician's non-surgical care) – U&C, up to $300

EXCLUSIONS

This Policy does not provide benefits for expenses resulting from:

7. 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.
8. 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. Treatment for re-Injury, EXCEPT when the Insured is treatment free for a period of 180 days prior to the Policy Effective Date.
6. The practice or play of KSHSAA interscholastic sports and activities including travel to or from such activity, practice, or play.
7. 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.

DEFINITIONS

Accident - means an unexpected, external and sudden event that is independent of any other cause.

Anesthesia - Benefits are payable for the administration of anesthesia when performed by a Physician or Certified Registered Nurse Anesthetist.

Coinsurance – means the percentage of eligible expenses that are payable as Benefits by the Company. The percentage is shown in the Schedule of Covered Services.

Company - means Ameritas Life Insurance Corporation.

Covered Services - means the services and supplies which are 1) Medically Necessary, 2) prescribed or performed by a Physician or Hospital for treatment of an Injury, 3) not excluded by this Policy, and 4) listed or named in this Policy's Schedule of Covered Services.

Dental Treatment – means Dentist's fees for surgery, x-rays, and other necessary dental services as a result of Injury to a Sound and Natural Tooth.

Diagnostic Imaging - means the images of the body created using other forms of radiology that does not include x-ray radiographs (films), including but not limited to: computerized axial tomography (CT); magnetic resonance imaging (MRI); radionuclide imaging (nuclear medicine); bone scans; and ultrasound (US). Benefit includes the fees for interpretation or reading of imaging results and the administration of contrast material.

Durable Medical Equipment – means medical equipment or device which can be rented, leased or purchased and which 1) is prescribed by a Physician; 2) is primarily and customarily used to serve a medical purpose; 3) can withstand repeated use; 4) generally is not useful to a person in the absence of Injury; and 5) is used exclusively by the Insured. Replacement equipment and devices are not covered. No benefits will be paid for rental charges in excess of purchase price. Durable Medical Equipment does not include non-prescription therapy devices or medical supplies; comfort and convenience items; corrective shoes; exercise and sports equipment. A written prescription must accompany the claim when submitted.

Expense Incurred – means the charge made for a service, supply, or treatment that is a Covered Service under this Policy. The expense is considered to be incurred on the date the service or treatment is given or the supply is received.

Hospital - means an institution which 1) is licensed by the state (if required) or other laws of jurisdiction; 2) is operated for the medical care and treatment of injured persons on an inpatient basis; 3) provides 24-hour nursing services or supervised by a graduate registered nurse; 4) has medical, diagnostic and treatment facilities with major surgical facilities on its premises or available to it on prearranged basis; 5) has a staff of one or more Physicians available at all times. It is not primarily a clinic, sanitarium, nursing home, skilled nursing facility, rest home or used for custodial or educational care, or an institution that mainly provides treatment for mental illness or substance abuse.

Injury - means an accidental bodily Injury or injuries directly caused by specific accidental contact with another body or object while the Insured is covered under this Policy. It is unrelated to any pathological, functional, or structural disorder. The Accident must result in an Injury which begins while the Insured is covered under this Policy.

Inpatient – means confinement in a Hospital for at least eighteen (18) or more consecutive hours.

Medically Necessary – means a Covered Service which is: 1) consistent with symptoms and diagnosis or treatment of Injury; 2) in accordance with standards of generally accepted medical practice; 3) not primarily for the convenience of the patient or Physician; and 4) most appropriate supply or level of service which can be safely provided.

Orthopedic Appliances – means a supportive appliance or device designed specifically for use in the correction or prevention of human deformities, defects of the skeleton, joints, or spine and which: 1) is prescribed by a Physician; 2) is primarily and customarily used to serve a medical purpose; 3) can withstand repeated use; 4) generally is not useful to a person in the absence of Injury; and 5) is used exclusively by the Insured. Replacement braces and appliances are not covered. A written prescription must accompany the claim when submitted.

Physician - means a doctor of medicine or osteopathy, or any other licensed health care provider that state law requires to be recognized as a Physician, other than the Insured or Insured's relative by blood or marriage, who is acting within the scope of such license.

Physiotherapy - means any form of therapeutic or manual treatment provided by a Physician, including but not limited to: physical or mechanical therapy, diathermy, ultrasonic treatment, EMS, whirlpool, heat treatments or manipulation. Includes office visit connected with the physiotherapy.

Prescription Drug – means a drug which has been determined to be safe and effective by the Food and Drug Administration and which can, under federal or state law, only be dispensed when ordered by a Physician who is duly licensed to prescribe such medication.

Residence - means the building and grounds where the Insured lives.

Sound and Natural Tooth - means the major portion of the individual tooth, formed by the human body, is present. Does not include teeth that are carious, abscessed, or defective.

Sponsored and Supervised Activity - means any activity which is exclusively sponsored by the Policyholder and which is under the direct and immediate supervision of an employee of the Policyholder.

Surgical Care – means Physician's fees for surgery. Surgical procedures are identified in the Surgery section of the Physicians' Current Procedural Terminology (CPT). Unless otherwise defined in the Schedule of Covered Services, if two or more procedures are performed through the same incision or at the same operative session, the maximum amount payable for the subsequent procedure(s) will not exceed 50% of the Usual and Customary Charges for the subsequent procedure(s).

Usual and Customary Charges (U&C) - means charges for medical services or supplies for which the Insured is legally liable and which do not exceed the average rate charged for the same or similar services or supplies in the geographic region where the services or supplies are received. Usual and Customary Charges for Covered Services - Supplies are determined by referencing the 75th percentile of the most current survey published by Fair Health Inc. for such Covered Service.

X-ray Services - Covered Services includes x-ray and radiology examination, consultation and fees for interpretation or reading of X-rays and other radiology results. Diagnostic X-rays are obtained from an x-ray machine and images are recorded on radiographs (films). This benefit does not include Diagnostic Imaging if listed as a separate benefit in the Schedule of Covered Services.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES

This Policy, including the endorsements and attached papers, if any, and the Policyholder's application constitute the entire contract of insurance. All statements made by the Policyholder shall, in the absence of fraud, be deemed representations and not warranties. No such statements will be used in defense to a claim under this Policy unless it is contained in the written application signed by, and furnished to, the Policyholder. No changes in this Policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon and attached hereto. No agent has authority to change this Policy or to waive any of its provisions. The Insured or beneficiary can request a copy of the application by requesting one in writing. The Company will furnish a copy of the application within fifteen (15) days of the day the Company received the request.

NOTICE OF CLAIM

Written notice of claim must be given to the Company's Administrative Office within thirty (30) days after the occurrence or commencement of any loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given in behalf of the Insured or the beneficiary to the Company's Administrative Office, 333 North Main Street, Suite 300, Stillwater, MN 55082, or its authorized agent, with information sufficient to identify the Insured, shall be deemed notice to the Company.

CLAIM FORMS

The Company, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proofs covering the occurrence, the character and the extent of loss for which claim is made.

PROOFS OF LOSS

Written proof of loss must be furnished to The Company's Administrative Office, 333 North Main Street, Suite 300, Stillwater, MN 55082 within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

PAYMENT OF CLAIMS

All benefits under the policy shall be payable to the person insured, or to his designated beneficiary or beneficiaries, or to his estate, except that if the person insured be a minor, such benefits may be made payable to his parents, guardian, or other person actually supporting him. Unless the Company is requested otherwise in writing not later than the time of filing proofs of loss, such indemnities may be paid directly to the hospital or person rendering such services; but it is not required that the services be rendered by a particular hospital or person. Payment so made shall discharge the Company's liability with respect to the amount of insurance so paid.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy and no such action shall be brought after the expiration of five (5) years after the time written proof of loss is required to be furnished in accordance with the requirements of this Policy.

ADDITIONAL POLICY PROVISIONS

EXCESS PROVISION

The Company's liability for benefits payable on account of expense incurred, for any hospitalization, medical, surgical, and other services resulting from covered Injury of the covered person, shall be limited to that part of the expense, if any, which is in excess of the total benefits payable for the same loss, on a provision of service basis or on an expense incurred basis under any medical or service contract, self-funded plan, automobile medical payment coverage, or any plan under federal, state or local law (except Medicaid). If one or more of the other policies, plans or service contracts provides benefits on an excess insurance or an excess coverage basis, benefits should be paid first by the company or service plan whose policy or service contract has been in effect for the longer period of time at the date of such loss.

EFFECTIVE DATE AND EXPIRATION DATE

Group coverage under this Policy with respect to each Insured shall become effective on the later of the following dates:

a) 12:01 a.m. following the date the application and premium payment is received by the Company's Administrative Office or its authorized agent; or
a) the Policy Effective Date, 08-01-2023.

Coverage under this Policy with respect to each Insured will end on the earliest of the following dates:

b) 11:59 p.m. on the date on which the Insured ceases to be enrolled in the School if the School-Time or Interscholastic sports and extracurricular activities coverage is purchased; or
b) 11:59 p.m. on the date on which the Insured ceases to be enrolled in the Special Risk activity; or
c) 11:59 p.m. on the last date of the period of coverage for which the premium was paid; or
d) 11:59 p.m. on the last date of the authorized season or activity for the Interscholastic Sports, Football or Special Risk Activity or other covered Activity of the current Policy period; or
e) 11:59 p.m. on the Policy Expiration Date, 07-31-2024.

PREMIUM

Special risk activities coverage requires 100% Participation, the premium for group coverage is paid by the Policyholder.

CLAIM PROCEDURE

Notify the Policyholder immediately when an Accident has occurred. Secure a claim form from the School, Servicing Agent, or from the Plan Administrator website, **www.sas-mn.com**. The Policyholder will complete Part A if it's a school injury. Parents or the student need to complete Part B of the claim form. Send the claim form and copies of all itemized doctor and hospital bills and other insurance explanation of benefits to:

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

Note: Proof of claim must be submitted to the address above within 90 days from the date of accident, or a reasonable time thereafter not to exceed one year. Itemized bills must be submitted within 90 days from the date of treatment or a reasonable time thereafter not to exceed one year. We are responsible only for expenses incurred within one year.

To check the status of your filed claim, questions regarding receipt of premium or verification of coverage may be answered by calling the Claims Office from 8:00 to 4:30 p.m. (Central Time), Monday – Friday or send an email. The toll free telephone number is 1-800-328-2739 or website is www.sas-mn.com.

Keep this certificate as your summary of coverage – no individual policy will be issued. A master policy is issued to the Policyholder. The master policy contains the contract provisions and shall prevail in the event of any conflict between this certificate and the master policy.

Privacy Notice:
You may obtain a copy of the Privacy Notice on the Student Assurance Services, Inc. website www.sas-mn.com.