Primary Voluntary Student Accident Plan
Underwritten by: AXIS Insurance Company
Administrator: Sportunderwriters.com, Inc

AT SCHOOL COVERAGE $40.00
Participating in or attending any Policyholder sponsored activity, excluding high school football, or while traveling to or from the Insured Person's residence and the Policyholder's premises on days when the Insured Person has regularly scheduled classes or at any other time if traveling by transportation furnished or approved by the Policyholder. School Covered Activities: 1. regularly-scheduled classroom instruction; 2. regularly-scheduled and supervised recess or lunch period; 3. a study period or special instruction period supervised by a member of the School's faculty; 4. a Supervised and Sponsored School Activity; or 5. Covered School Travel.

24 HOUR COVERAGE $150.00
The Company will pay the Benefit Amount shown in the Schedule of Benefits, subject to all applicable conditions and exclusions, when the Insured Person suffers a Covered Loss that occurs any time while insured by this Policy.
Exclusions This coverage will not be in effect while the Insured Person is participating in any activity, including tryouts, practice or any competitions or games for Interscholastic High School tackle football for students in the 9th grade or above, or Junior High and Middle School students participating with students in the 9th grade or above in Interscholastic tackle football.

FULL FOOTBALL SEASON $300.00 SPRING FOOTBALL $125.00
Practice or play of high school football in accordance with the rules of the state high school athletics authority. Group or team travel supervised by the Policyholder to or from a practice or play is covered if in a vehicle furnished or approved by the Policyholder. The Company will pay the Benefit Amount shown in the Schedule of Benefits, subject to all applicable conditions and exclusions, when the Insured Person suffers a Covered Loss that occurs while He is participating in or attending one of the following sports Covered Activities: 1. regularly-scheduled practice or training; 2. regularly-scheduled competition or exhibition game; 3. a scheduled tryout, workout session or team meeting; 4. a Supervised and Sponsored Sports Activity; or 5. Covered Sports Travel.

ACCIDENT MEDICAL BENEFIT
The policy provides benefits for loss due to a Covered Injury up to the Total Maximum for all Accident Medical Benefits of $50,000 for each Covered Accident. There is no deductible. The benefit limit for Covered Losses from any one Motor Vehicle Accident is $2,500. Medical treatment must be provided by a qualified, licensed Physician and must begin within 90 days from the date of the Covered Accident. Benefits will be payable for Covered Expenses incurred within 52 weeks from the date of the Covered Accident up to the maximum Benefit Amount per service as shown on the Schedule of Benefits of the Policy.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS
Covered Loss must occur within 365 days of the Covered Accident. Principal Sum: $5,000. Dismemberment Benefit: $10,000. Exposure and Disappearance is included.

Covered Loss	Benefit Amount
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Dismemberment Benefit
Loss of Sight of Both Eyes	100% of the Dismemberment Benefit
Loss of Speech and Hearing (in Both Ears)	100% of the Dismemberment Benefit
Loss of One Hand or Foot and Sight in One Eye	100% of the Dismemberment Benefit
Loss of One Hand or Foot	50% of the Dismemberment Benefit
Loss of Sight in One Eye	50% of the Dismemberment Benefit
Loss of Speech	50% of the Dismemberment Benefit
Loss of Hearing (in Both Ears)	50% of the Dismemberment Benefit
Loss of Hearing in One Ear	25% of the Dismemberment Benefit
Loss of Thumb and Index Finger of the same Hand	25% of the Dismemberment Benefit

SCHEDULE OF ACCIDENT MEDICAL BENEFITS

Determination of the amount of each Covered Expense, and where applicable, each Usual and Customary Charge, will be made by the Company.

Covered Expenses	Benefit Percentage and Other Limits
Expanded Medical Benefit For Covered Sports Conditions	100% of Usual and Customary Charges (Covered Sports Conditions: bursitis; sprains; hernia; muscle tears; tendonitis; and repetitive motion injuries)
Heart and Circulatory Conditions Covered Heart and Circulatory Conditions	100% of Usual and Customary Charges heat exhaustion; heart attack; cardiac arrest, stroke; burst aneurysm
Inpatient Hospital Services Room and Board Expenses Intensive Care Unit Private/Semi-Private Room	 $250 per day subject to maximum of $1,000 $200 per day
Miscellaneous Expenses In-Hospital Physiotherapy Nurse Services Orthopedic Appliances Pre-Admission Tests	80% of Usual and Customary Charges subject to maximum of $1,200 Included in above maximum Included in above maximum Included in above maximum Included in above maximum
Ambulatory Medical Center	$350 maximum
Emergency Room Treatment	$200 maximum
Physician Services	
Surgery	50% of Usual and Customary Charges subject to maximum of $1,250
*Allowance is calculated: 100% of Usual and Customary Charges for the 1st procedure, 50% of Usual and Customary Charges for the 2nd procedure, and 25% of Usual and Customary Charges for each additional procedure when performed through different incisions/portals.	
Assistant Surgeon	$315 maximum
*Allowance is calculated: 25% of Usual and Customary Charges for the surgery performed as indicated above.	
Anesthesia and its Administration	$315 maximum
*Allowance is calculated: 25% of Usual and Customary Charges for the surgery performed as indicated above.	
Use of Physician's Surgical Facilities Physician Assistant Second Opinion or Consultation In-Hospital Visits Office Visits	$350 maximum Not covered $50 maximum $40 first visit, $25 for subsequent visits. Limited to one visit per day. $40 first visit, $25 for subsequent visits. Limited to one visit per day.
Outpatient X-ray	$250 maximum
Outpatient CT Scan, MRI and Laboratory Tests	$300 maximum
Outpatient Physiotherapy	$25 per visit subject to maximum of 10 visits (includes acupuncture; microthermy; manipulation; diathermy; massage therapy; heat treatment; and ultrasonic treatment)
Outpatient Nursing Services	100% of Usual and Customary Charges
Ambulance Services (Air and Ground)	$150 maximum
Medical Equipment Rental	$75 maximum (Includes Orthopedic devices)
Medical Services and Supplies	$75 maximum
Dental Services	$150 per tooth
Prescription Drugs	$25 maximum
Eyeglasses, Contact Lenses, Hearing Aids	$150 maximum

COMMON EXCLUSIONS

In addition to any benefit or coverage specific exclusion, benefits will not be paid for any loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the Description of Benefits Section or Conditions of Coverage Section:

1. intentionally self-inflicted injury, suicide, or any attempt while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. declared or undeclared war or act of war or any act of declared or undeclared war unless specifically provided by this Policy;
5. flight in, boarding or alighting from an Aircraft, except as a passenger on a regularly scheduled commercial airline;
6. travel in any Aircraft owned, leased operated 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;
7. sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, (including exposure, whether or not Accidental, to viral, bacterial or chemical agents) whether the loss results directly or non directly from the treatment except for any bacterial infection resulting

from an Accidental external cut or wound or Accidental ingestion of contaminated food;
8. voluntary ingestion of any narcotics, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
9. injuries compensable under Workers' Compensation law or any similar law;
10. operating any type of vehicle or Conveyance while under the influence of alcohol or narcotics or other intoxicant including any prescribed drug for which the Insured Person has been provided a written warning against operating a vehicle or Conveyance while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the motor vehicle laws of the state in which the Covered Loss occurred;
11. the Insured Person's intoxication. The Insured Person is conclusively deemed to be intoxicated if the level in His blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be under the influence of alcohol if operating a motor vehicle, regardless of whether He is in fact operating a motor vehicle, when the injury occurs. An autopsy report from a licensed medical examiner, law enforcement officer's report, or similar items will be considered proof of the Insured Person's intoxication;
12. an Accident if the Insured Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless: (a) the Insured Person holds a valid learners permit and (b) the Insured Person is receiving instruction from a driver's education instructor;
13. aggravation, during a Covered Activity, of an injury the Insured Person suffered before participating in that Covered Activity unless the Company receives a written medical release from the Insured Person's Physician;
14. medical or surgical treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice unless it occurs during treatment of a Covered Injury; or
15. benefits will not be paid for services or treatment rendered by any person who is: a. employed or retained by the Policyholder; b. living in the Insured Person's household; c. an Immediate Family Member, including domestic partner, of either the Insured Person or the Insured Person's Spouse; or d. the Insured Person.

ACCIDENT MEDICAL BENEFIT LIMITATIONS AND EXCLUDED EXPENSES

Limitation for Contributory School and/or Sports Coverage: If benefits are payable for any Covered Loss under this Policy and under another blanket accident insurance policy issued by the Company for which the Policyholder pays the entire premium:
1. benefits will be payable first under that policy; and
2. the total benefits payable under both policies will not exceed the maximum benefit amount in the policy that provides the greater maximum.

Limitation For Motor Vehicle Accidents: Benefits will be paid for Covered Expenses incurred for treatment of Covered Injuries that result directly and independently of all other causes from a Covered Loss that occurred while the Insured Person was riding in or driving a Motor Vehicle. Benefits will not exceed the Benefit Amount shown in the Schedule of Benefits.

The following will not be considered Medically Necessary Covered Expenses unless coverage is specifically provided:
1. cosmetic surgery, except for reconstructive surgery needed as the result of a Covered Injury;
2. any elective or routine treatment, surgery, health treatment, or examination, including any service, treatment of supplies that: (a) are deemed by the Company to be experimental or investigational; and (b) are not recognized and generally accepted medical practice in the United States;
3. examination or prescriptions for, or purchase, repair or replacement of wheelchairs, braces, appliances, orthopedic braces, or orthotic devices;
4. repair or replacement of existing dentures, partial dentures, braces or bridgework;
5. repair or replacement of existing artificial limbs, eyes and larynx.
6. treatment of an injury resulting from a condition that the Insured Person knew existed on the date of a Covered Accident, unless the Company has received a written medical release from his Physician;
In no event will the Company's total payments for the Insured Person exceed the Total Maximum for all Accident Medical Benefits shown in the Schedule of Benefits.

Disclaimers

THIS IS A BLANKET ACCIDENT ONLY POLICY.

U.S. Insurance coverage is underwritten by AXIS Insurance Company. Coverage is subject to exclusions and limitations, and may not be available in all US states and jurisdictions. Product availability and plan design features, including eligibility requirements, descriptions of benefits, exclusions or limitations may vary depending on local country or US state laws. Full terms and conditions of coverage, including effective dates of coverage, benefits, limitations, and exclusions, are set forth in the policy.

THIS INSURANCE DOES NOT COORDINATE WITH ANY OTHER INSURANCE PLAN. IT DOES NOT PROVIDE MAJOR MEDICAL OR COMPREHENSIVE MEDICAL COVERAGE AND IS NOT DESIGNED TO REPLACE MAJOR MEDICAL INSURANCE. FURTHER, THIS INSURANCE IS NOT MINIMUM ESSENTIAL BENEFITS AS SET FORTH UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT.

The coverage is underwritten by AXIS Insurance Company under group policy form series number BACC-001-0909-SCH-TX

ENROLLMENT FORM

Student's Last Name	
Student's First Name and Middle Initial	
Birth Date (MM/DD/YYYY)	
Grade, and Phone Number	
Home Street Address	
City, State, and Zip	
School System/District	
School Name	
Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.	
Signature of Parent or Guardian, and Date	
My signature above certifies that I have read and understand this brochure and agree to accept the terms and conditions stated herein.	
Check your selection:	
☐ 1. At-School Coverage	$40.00 Premium Rate Per Student
☐ 2. 24-Hour Coverage	$150.00 Premium Rate Per Student
☐ 3. Full Football Season	$300.00 Premium Rate Per Student
☐ 4. Spring Football	$125.00 Premium Rate Per Student
☐ 5. At School + Football (full season)	$340.00 Premium Rate Per Student
☐ 6. At School + Football (spring)	$165.00 Premium Rate Per Student
☐ 7. 24 hour + Football (full season)	$450.00 Premium Rate Per Student
☐ 8. 24 hour + Football (spring)	$275.00 Premium Rate Per Student

Effective Date: Insurance becomes effective for the Eligible Person who enrolls and agrees to make the required contributions, on the latest of the following dates: 1. the Policy Effective Date; 2. the date the person becomes eligible; 3. the day after the Company receives the Eligible Person's completed enrollment form and the required premium payment. In no event will insurance for the Eligible Person become effective before the Policy Effective Date.

Termination of Insurance: Insurance for the Insured Person will end on the earliest of: 1. the date the person is no longer in an Eligible Class; 2. the end of the period for which the last premium is made; or 3. the date this Policy ends. Termination does not affect a claim for a Covered Loss due to a Covered Accident that occurs before the termination date. However, in no instance will benefits extend beyond the earliest of: 1. the end of the Benefit Period; and 2. the date benefits equal to any applicable benefit limit or maximums, as shown in the Schedule of Benefits, have been paid

HOW TO ENROLL

1. Decide whether you want the At-School, 24 Hour, Full Football or Spring Football coverage
2. Fill out the enrollment form and enclose the form along with a check or money order made payable to CBG Services Corporation for the correct amount. An enrollment form is required for **each** child.
3. Mail envelope to CBG Services Corp., PO Box 164195, Austin, TX 78716.

Your cancelled check or money order stub will be your receipt and confirmation of payment. Please write the student's name and school name on your check.

FOR QUESTIONS, INQUIRIES, AND INFORMATION CONTACT

p: 1 (800) 749-6458

Combined Benefits Group
PO Box 164195
Austin, TX 78716

How to file a Medical Claim

(For Special Risk, Sports, Campers, Youth Groups, and Participant Accident Insurance Policies) Attached is a claim form for your accident policy.

Please forward claims and questions to the following address: 90 Degree Benefits
PO Box 6540
Harrisburg, Pa 17112
Ph: 1-800-427-9308
Fax: (717) 652-8328
Email: Student.Insurance@90degreebenefits.com

Step 1: The Participating Organization (NOT the Parent, Claimant or Agent) should:

- Fully answer each item in Part I, The Participating Organization Statement.
- Read the fraud warning statement on page 3 and sign the form where indicated in Part I.

Step 2: The Parent/Guardian or Adult Claimant Should:

- Fully answer each item in Part II, including the claimant's personal information, parent's information, along with other insurance information.
- In order to ensure we receive complete claim information, we require providers to submit standardized itemized bills (called "**UB04"** for hospital charges and/or a "**CMS-1500**" for physician charges).
- Providers may bill us directly. If they do, please ensure a completed claim form has first been submitted to our office.
- If other insurance exists, include the other insurance company's corresponding Explanation of Benefits (EOBs). **We are Primary over State provided Insurance (i.e. all Medicaid programs) and Non-active Duty TRICARE.**
- Unless proof of payment is submitted with the medical bill (a copy of the check, a medical bill that indicates the claimant has made all or partial payment, or zero balance information) claim payment is sent directly to the medical providers.
- Review Part III, Authorizations
- Read the fraud warning statement on page 3 and sign where indicated on the bottom of the Claim Form.

Helpful information for submitting claims

- A fully completed Claim Form is required for each accident/injury. Claims submitted with incomplete information will be sent back to injured party, to complete missing information.
- The acceptance of a claim form by an insurance company is not an admission of coverage.
- The claimant must seek treatment, resulting in a medical expense, within 90 days of the injury. Contact our office for verification.
- Written proof of loss must be furnished to the Company within 90 days after the date of the Covered Loss or as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

Step 3: Submit the Completed Notice of Claim (Claim Form) via either by mail, fax, or email listed above. Please note: if sending information via email, it is only used to receive incoming information. Any questions about claims please call our office.

1. Please Fully Complete This Form
2. See Filing Instructions Attached
3. Mail To

90 Degree Benefits
PO Box 6540
Harrisburg, PA 17112
Phone: 1-800-427-9308
Fax: 717-652-8328
Email: Student.Insurance@90degreebenefits

PART I - PARTICIPATING ORGANIZATION STATEMENT

Policy Number:	Organization Name:	Event, Activity, or Sport:
Claimant's Name (Injured Person)	The Injured Person Was A: ☐ Participant ☐ Staff Member ☐ Other	Date and Time Of Accident:
Place Where Accident Occurred:	Type of Injury: (Indicate Part Of Body Injured - e.g. broken arm, etc.)	

Describe How Accident Occurred - Provide All Possible Details:

Dental Claims	Indicate Which Teeth Were Involved:	Describe Condition of Injured Teeth Prior To Accident: ☐ Whole, Sound & Natural ☐ Filled ☐ Capped ☐ Artificial

Did Accident (Check Yes or No for Each of The Following):

A.	During A Participating Organization Sponsored & Supervised, or Sanctioned Activity?	☐ YES	☐ No
B.	On Activity Premises:	☐ YES	☐ No
C.	While Traveling Directly and Uninterruptedly to Or Form the Activity?	☐ YES	☐ No
D.	During A Participating Organization Practice or Competition?	☐ YES	☐ No
E.	Did Injury Result in Death:	☐ YES	☐ No

Signature of Participating Organization Representative:	Name & Title of Participating Organization Representative:	Date:

PART II - PARENT, RESPONSIBLE PARTY, OR GUARDIAN STATEMENT

Best Contact Number (Included Area Code):	Social Security Number (Of Injured):	Gender (Of Injured): ☐ M ☐ F	Date of Birth (Of Injured):

Address (in which information should be mailed to):

Do you/spouse/parent have medical/health care, or are you enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through an employer, a parent's employer, or other source? ☐ YES ☐ No

If yes, name of insurance company: _____ Policy #: _____

Are you eligible to receive benefits under any governmental plan or program, including Medicare? ☐ YES ☐ No

If yes, please explain: _____

Mother (Guardian's) primary employer name, address & telephone: _____

Father (Guardian's) primary employer name, address & telephone: _____

PART III - AUTHORIZATIONS

I authorize medical payments to physician or supplier for services described on any attached statements. If not signed, provide proof of payment.

SIGNATURE: _____ **DATE:** _____

I authorize any physician, medical professional, hospital, covered entity as defined under HIPPA, insurer or other organization or person having any records, dates or information concerning the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records or all such records in their entirety to **AXIS Insurance Company** or its designated administrator. A photo static copy of this authorization shall be considered as effective and valid as the original.

I agree that should it be determined at a later date there is other insurance (or similar), to reimburse **AXIS Insurance Company** to the extent of any amount collectible. I understand that any person who knowingly and with the intent to defraud or deceive any insurance company; files a claim containing any material by false, incomplete, or misleading information, may be subjected to prosecution for insurance fraud.

SIGNATURE: _____ **DATE:** _____

Important Notice

- ***In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and West Virginia:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ***For Residents of Alabama:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines and confinement in prison, or any combination thereof.
- ***For residents of Colorado:*** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- ***For residents of the District of Columbia:*** *WARNING:* It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- ***For residents of Florida:*** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- ***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- ***For residents of Maine, Tennessee and Washington:*** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
- ***For residents of Oregon:*** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.
- ***For residents of Maryland:*** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- ***For residents of New Mexico:*** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
- ***For residents of New York:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- ***For residents of Ohio:*** 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.
- ***For residents of Oklahoma:*** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
- ***For residents of Pennsylvania:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- ***For residents of Texas:*** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- ***For resident of Virginia:*** 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 false or deceptive statement may have violated state law.