

STUDENT ACCIDENT INSURANCE

2020-2021 SCHOOL YEAR

This is a reminder to parents with a child or children **attending** school in our School District that we do not carry medical insurance on students, but do provide parents with the opportunity to select a primary accident insurance plan for students. Student accident insurance can help you manage the possibility of out-of-pocket expenses, since many group insurance policies no longer pay full hospital and medical expenses and may require a deductible or co-insurance. There are two plans available for your consideration neither option includes interscholastic sports:

- **Plan #1 School Time Coverage** – Costs \$22 per student – This will cover injury occurring while the student is traveling to and from school, while attending school sponsored activities such as plays, assemblies, class trips, intramural sports, gym and physical education classes, etc.
- **Plan #2 24 Hour Coverage** – Costs \$88 per student – This will cover all of the above, plus accidents occurring away from school, in the evenings and on weekends, vacations, etc.

Please note that the plans should be considered in conjunction with any other family medical insurance you may have.

Please see the attached Brochure for a complete description of the plans and the various coverage options. If you have any questions, please call an Insurance Broker at Alive Risk directly at (215) 946-8888 between 8:00 and 4:30 p.m.

PLEASE DO NOT SEND CASH!! Completed applications (found on the last page of the attached brochure) should be returned by mail with a check or money order for the correct premium, directly to:

A&H Lockbox
P.O. Box 45731
Baltimore, MD 21297

DO NOT RETURN THE APPLICATION & PAYMENT TO YOUR STUDENT'S SCHOOL

This insurance can be purchased anytime during the 2020-2021 school year.

Parents enrolling more than one child must fill out an application for each child/student, write a separate check or obtain a money order for each child/student being enrolled and mail in separate envelopes to the address above. Your cancelled check or money order receipt is your proof of payment. Thank you!

Up to \$1,000,000 Voluntary Student Accident Medical Insurance Protection



Administered By: **ALIVE RISK**

(215) 946-8888

2020-2021

Underwritten by:

AXIS INSURANCE COMPANY

IMPORTANT NOTICE

This Brochure provides a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the policy issued in Pennsylvania under form number BACC-001-0909-PA. Complete details are found in the policy on file at your school's office. The policy is subject to the laws of the state in which it was issued. Please keep this information for your reference.

THIS INSURANCE 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. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE ADDITIONAL PAYMENT WITH YOUR TAXES.

BEST BUY 24-HOUR COVERAGE

Around-the-clock accident coverage for your child at any time. Insurance Protection during vacations, weekends and school days.

24-Hour Coverage is your best buy because it is not limited to school connected accidents but also covers accidental Injury at home or away. ANY COVERED ACTIVITY - ANYTIME - ANYWHERE. Continuous Insurance protection from the effective date to the opening of the next school term.

Coverage becomes effective on the date the Application and Premium are received by the administrator. Once effective, coverage continues until the first day of school in the following year or until the policy with the school expires, whichever occurs first.

SCHOOL TIME ACCIDENT COVERAGE

Insurance coverage for the hours and days when school is in session and while attending school sponsored and supervised activities.

- During school year • School supervised activities
- On the school premises • Class trips
- Travel to and from school

This coverage is subject to the terms and conditions stated in the policy.

ACCIDENTAL DEATH AND DISMEMBERMENT OR LOSS OF SIGHT

When Injury results in an Insured's death, the Company will pay a \$5,000 accidental death benefit. When Injury results in any one of the following covered losses within 365 days from the date of a covered accident, the Company will pay the benefit shown in the schedule below. Only one benefit, the largest, will be paid for more than one loss (including death) resulting from the same covered accident.

| Covered Loss | Benefit Amount |
|---|--|
| Loss of Life | As shown on the Master Insurance Application |
| Loss of Two or More Hands or Feet | \$20,000 |
| Loss of Sight of Both Eyes | \$20,000 |
| Loss of One Hand or Foot and Sight in One Eye | \$20,000 |
| Loss of One Hand or Foot | \$10,000 |
| Loss of Sight in One Eye | \$10,000 |
| Loss of Thumb and Index Finger of the same Hand | \$10,000 |
| Loss of all Four Fingers of the Same Hand | \$10,000 |

| | |
|-----------------------------------|-----------------|
| Exposure and Disappearance | Included |
|-----------------------------------|-----------------|

Loss of a Hand or Foot means complete Severance through or above the wrist or ankle joint.

Loss of Sight means the total, permanent Loss of Sight of one eye. The Loss of Sight must be irrecoverable by natural, surgical or artificial means.

Loss of a Thumb and Index Finger of the Same Hand or Loss of Four Fingers of the Same Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).

Severance means complete separation and dismemberment of the part from the body.

OPTIONAL \$100,000.00 ACCIDENTAL DENTAL BENEFIT

By adding \$8.50 to your premium payment, dental benefits will be extended to provide payment for the Usual and Customary Expenses incurred within two years from the date of a covered accident for injury to sound and natural teeth, up to a maximum of \$100,000 per covered accident, provided treatments and services begin within 90 days from the date of the covered injury. The following services are included in this benefit:

1. Replacement of caps, crowns, dentures, and orthodontic appliances (including braces) fillings, inlays, crozat appliances, endodontics, oral surgery, examinations and x-ray services required as a result of Injury.
2. In no event shall the Company's payment exceed the usual and customary charge normally made by a Dentist for necessary treatment actually rendered during the 104-week period immediately following the date of Injury; if there is more than one way to treat a Dental issue, the Company will pay benefits for the least expensive procedure provided that this meets acceptable dental standards.
3. When a dentist certifies to the Claim Administrator that treatment will continue beyond the two year benefit period, a maximum of \$1,500 will be paid. Treatment must be completed within two years of the expiration of the initial treatment period. This benefit is in effect 24 hours a day, even when purchased with School Time Accident Coverage.

STUDENT ACCIDENT INSURANCE PROTECTION PROVIDING A MAXIMUM OF \$1,000,000 ACCIDENT MEDICAL EXPENSE BENEFITS

The company will pay the Usual and Customary Charges incurred for a Covered Injury, if first treatment is received within 90 days after the Injury. The Schedule of Benefits is stated below. Benefits are payable up to a maximum of 52 weeks after the date of the covered Injury.

PRIMARY COVERAGE

Benefits are payable for covered medical expenses from the first dollar, no deductible, no coinsurance, paying in addition and without regard to payments by other insurance up to maximums stated herein. Benefits are payable for a maximum of 52 weeks.

Total Maximum for all Accident Medical Benefits: \$1,000,000

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

Intensive Care Unit: Usual and Customary Charges, not to exceed \$1,000 per day for 7 days

Semi-Private Room: Up to \$500 per day

Hospital Miscellaneous Expenses: Usual and Customary Charges up to \$5,000

In-Hospital Physiotherapy: Usual and Customary Charges, up to a maximum of 10 visits

Nurse Services: Usual and Customary Charges

Orthopedic Appliances: In Hospital: up to a maximum of \$950/Out of Hospital: up to a maximum of \$500

Ambulatory Medical Center: Usual and Customary Charges

Emergency Room Treatment (when Hospital Confinement is not required): up to a maximum benefit of \$300

Physician Services:

- **Surgery:** Usual and Customary Charges in accordance with the 1974 Revised California Relative Value Studies, 5th Edition having a conversion factor of \$150.00 Unit Value
- **Assistant Surgeon:** 35% of Surgery Allowance
- **Second Opinion or Consultation:** up to a maximum of \$150
- **Anesthesia and its Administration:** 35% of Surgery Allowance
- **In-Hospital Visits:** Usual and Customary Charges
- **Office Visits:** Usual and Customary Charges

Outpatient X-ray, CT Scan, MRI: up to a maximum of \$350

Outpatient Laboratory Tests: up to a maximum of \$350

Outpatient Physiotherapy: \$40 per visit, up to a maximum of 10 visits

Outpatient Nursing Services: Usual and Customary Charges

Ambulance Services (Air and Ground): Usual and Customary Charges

Dental Services: \$400 per tooth / Usual and Customary Charges for braces

Prescription Drugs: Usual and Customary Charges

Eyeglasses, Contact Lenses, Hearing Aids:

Usual and Customary Charges

The following will not be considered Medically Necessary Covered Expenses unless coverage is specifically provided:

1. expenses payable by any automobile insurance policy without regard to fault;
2. cosmetic surgery, except for reconstructive surgery needed as the result of a Covered Loss;
3. examination or prescriptions for, or purchase, repair or replacement of, eyeglasses, contact lenses; or
4. services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay.

Exclusions apply to the Accident Medical Expense Benefit and the Accidental Death and Dismemberment Benefit:

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 Policy.

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. parachuting;
7. travel in or on any off-road motorized vehicle that does not require licensing as a motor vehicle;
8. 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 indirectly from the treatment except for any bacterial infection resulting from an Accidental external cut or wound or Accidental ingestion of contaminated food;
9. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
10. injuries compensable under Workers' Compensation law or any similar law;
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. practice or play in Senior High Interscholastic Football and/or Senior High Interscholastic Sports, including travelling to and from games and practice, unless specifically provided for in the Master Insurance Applications;
13. participation in any sports activity not specifically authorized, sponsored and supervised by the Policyholder, whether or not it takes place on the Policyholder's premises or during normal School hours, including snowboarding, skiing and ice hockey;
14. 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.

LIMITATIONS: any Covered Injury occurring, and expenses incurred therefrom, as a result of a Covered Accident which occurs while an Insured Person is engaged in an activity which is covered under the School's Compulsory Plan, will not be covered under a Voluntary Plan.

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit Us from providing insurance, including, but not limited to, the payment of claims.

Disclosure

US 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. This insurance provides limited benefits. Limited benefits plans are insurance products with reduced benefits and are not intended to be an alternative to or integrated with comprehensive coverage. Further, 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.

To File A Claim:

1. To download a claim form, go to: www.aliverisk.com
2. Fill out all necessary information
3. Be sure to sign and date the bottom
4. Enclose itemized bills, paid receipts and/or other insurance explanation of benefits.
5. Send claim forms, itemized bills and receipts to:

**MCA Administrators, Inc.
PO Box 6540
Harrisburg, PA 17112
(800) 427-9308**

Proof of Loss is required within 90 days from the date of the Accident. You have ONE year from the time Proof of Loss would have been required to file a claim. Claims submitted past this period will not be considered for payment under the policy.

ENROLLMENT FORM CHECKLIST

Did You:

- ☐ Fill out all of the appropriate information on the enrollment form (MAKE SURE SCHOOL DISTRICT IS CLEARLY LISTED)
- ☐ Check the appropriate box(s) for the coverage you have selected.
- ☐ Enclose a CHECK or MONEY ORDER for the total Premium (your cancelled check or money order stub will serve as proof of payment) along with the completed enrollment form in an envelope.

For questions, inquiries, and information contact:

Alive Risk

(888) 533-7654

(215) 946-8888

DO NOT SEND CASH

Enrollment Form

Please Print

Pennsylvania 2020-2021

| | | |
|---|----------------|-------|
| STUDENT'S LAST NAME | | |
| STUDENT'S FIRST NAME | MIDDLE INITIAL | |
| BIRTH DATE (MM/DD/YYYY) | GRADE | PHONE |
| HOME ADDRESS | APT# | |
| CITY | ST | ZIP |
| SCHOOL SYSTEM/DISTRICT | | |
| SCHOOL NAME | | |
| <p>The applicant represents the information contained in this application is true and correct and forms the basis of the requested insurance. 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.</p> | | |
| SIGNATURE OF PARENT OR GUARDIAN | | DATE |

My signature above certifies that I have read and understand the Student Accident Insurance Protection brochure and agree to accept the terms and conditions stated herein.

No obligation to purchase.

| School Year Rate – 2020-2021 – CHECK ✓ YOUR SELECTION | |
|--|----------------------------------|
| Coverage Plans | Premiums |
| BEST BUY! 24-Hour | <input type="checkbox"/> \$88.00 |
| School Time | <input type="checkbox"/> \$22.00 |
| Dental Accident Insurance (with either of the above plans) | <input type="checkbox"/> \$8.50 |

Make checks payable to:
Alive Risk

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| <p>How to Enroll</p> <ol style="list-style-type: none">1. Decide whether you want the School time, 24-Hour Accident Protection or Dental Plan.2. Fill out the enrollment form and enclose the form along with a check or money order made payable to the Administrator shown for the correct amount.3. Mail envelope to A&H Lockbox – PO Box 45731 – Baltimore, MD 21297 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.) |
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