STUDENT ACCIDENT INSURANCE
2017- 2018 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 excess group 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:

- **Plan #1 School Time Coverage** – Costs $30 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 $116 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 American Management Advisors directly at (215) 946-8888 between 8:00a.m. and 4:30 p.m.

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

American Management Advisors, Inc.
P.O. Box 366
Langhorne, PA 19047-0366

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

This insurance can be purchased anytime during the 2017-2018 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** Student Accident Medical Insurance Protection



Administered By:

AMERICAN MANAGEMENT ADVISORS, INC.

P.O. Box 366, Langhorne, PA 19047-0366

(215) 946-8888

2017-2018

Underwritten By:

AXIS Insurance Company

Chicago, Illinois

Ver. 1

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 American Management Advisors, Inc.. Once effective, coverage continues until the first day of school in the following year or until the Master Policy with the school expires, whichever occurs first. This coverage is subject to the terms and conditions stated in the Master Policy.

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 Master Policy.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

When a Covered Injury results in an Insured Person's death, the Company will pay a $5,000 accidental death benefit. When a Covered 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.

Loss of Two or more hands or Feet	$20,000
Loss of Use of Two or More Hands or Feet:	$20,000
Loss of Sight of Both Eyes:	$20,000
Loss of Sight in One Eye:	$20,000
Loss of One Hand or Foot and Sight in One Eye:	$20,000
Loss of Use of One and Foot and sight in one eye	$20,000
Loss of One Hand or Foot	$10,000
Loss of Use of One Hand or Foot:	$10,000
Loss of Sight in One Eye:	$10,000

"Loss of a Hand or Foot" means complete Severance through or above the wrist or ankle joint. "**Loss of Use of a Hand or Foot"** means total loss of all ability to move the hand or foot, within 30 days of a Covered Accident, that continues for 6 months and is expected to continue for the remainder of the Insured Person's lifetime. "**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. **"Severance"** means complete separation and dismemberment of the part from the body.

ACCIDENTAL DENTAL CARE AND SURGICAL BENEFIT

By adding $8.50 to your premium payment, dental benefits will be extended to provide payment for the Usual and Customary Charges incurred within two years from the date of a Covered Accident for a Dental Injury up to a maximum of $100,000 per Dental Injury, provided treatments and services begin within 90 days from the date of the Dental Injury.
The following services are included in this benefit:

1. X-rays, to repair injury to a tooth (1) with no fillings or cavities or only fillings or cavities that do not undermine the tooth cusps; and (2) for which pulpal tissues are healthy and intact; and (3) for which periodontal tissue shows little or no signs of active or chronic inflammation; or to the supporting structures of the teeth of Insured Person.
2. In no event shall the Company's payment exceed the Usual and Customary Charges normally made by a Dentist for necessary treatment actually rendered during the 1 04-week period immediately following the date of the Dental Injury. If there is more than one way to treat a Dental Injury, the Company will pay benefits for the least expensive procedure provided that this meets acceptable dental standards.
3. When a dentist certifies in writing to the Claim Administrator that treatment will continue beyond the two year benefit period, an additional $1,500 will be paid. Treatment must be completed within two years of the expiration of the initial benefit paying period. This benefit is in effect 24 hours a day, even when purchased with School Time Accident Coverage.

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.

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 EXCESS COVERAGE: The Company will pay the first $100 of covered expense for any one claim resulting from any one covered accident without regard to other insurance. Thereafter, benefits will be payable for covered expenses above $100.00 that are not recoverable from other valid and collectible group insurance. If the Insured is not covered by other insurance, full benefits will be payable as described in the Schedule of Benefits. Benefits are payable for a maximum of 52 weeks.

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 7 days
Semi-Private Room: Usual and Customary Charges
Personal Services and Supplies: Usual and Customary Charges
Inpatient X-ray, CT scan, MRI: up to a maximum of $650
Inpatient Laboratory Tests: up to a maximum of $650
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: Usual and Customary Charges
Pre-Admission Tests: Usual and Customary Charges
Ambulatory Medical Center: Usual and Customary Charges
Emergency Room Treatment (when Hospital Confinement is not required): Usual and Customary Charges, subject to a maximum of $400
Physician Services: Usual and Customary Charges
Surgery: Usual and Customary Charges in accordance with the 1974 Revised California Relative Value Studies, 5th Edition having a conversion factor of $180.00 Unit Value
Assistant Surgeon: 40% of Surgery Allowance
Physician Assistant: Usual and Customary Charges
Use of Physician's Surgical Facilities: Usual and Customary Charges
Second Opinion or Consultation: Usual and Customary Charges
Anesthesia and its Administration: 40% 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 $650.00
Outpatient Laboratory Tests: up to a maximum of $650.00
Outpatient Physiotherapy: $50 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: Usual and Customary Charges
Prescription Drugs: 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; and (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. The Policy does not cover any Covered Loss incurred as a result of:

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 Application;
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.
When Excess Insurance is provided and another Plan Providing Medical Expense Benefits to an Insured is an HMO, PPO, or similar arrangement for provision of benefits or services and the covered accident occurs within the geographic area of the HMO, PPO, or similar arrangement for provision of benefits or services and the Insured does not use the facilities of the HMO, PPO, or similar arrangement for provision of benefits or services, the medical benefits otherwise payable under the policy shall be reduced by 50%. This limitation shall not apply to emergency treatment required within 24 hours after an accident or when the covered accident occurs outside the geographic area served by the HMO, PPO, or similar arrangement of benefits or services.
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.

NOTE: It is not the intent of the Company to unfairly reduce benefit for any Insured if the Insured is outside the Network Area of the HMO, PPO, or similar arrangement for benefits or services and no benefits are available. The reduction of benefits is only for those Insured Persons who can use their HMO, PPO, or similar arrangement for benefits or services and have not done so.

To File A Claim:

1. To download a claim form, go to: www.amastudentplans.com
2. Fill out parts A and B
3. Be sure to sign and date the bottom
4. Enclose any itemized bills or receipts from services rendered.
5. Send claim forms, itemized bills and receipts to:

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

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:

American Management Advisors, Inc.
PO Box 366
Langhorne, PA 19047
(888) 533-7654
(215) 946-8888

DO NOT SEND CASH

Enrollment Form

Please Print

Pennsylvania 2017-2018

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

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.

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 – 2017-2018 – CHECK ✓YOUR SELECTION

Coverage Plans	Premiums
BEST BUY! 24-Hour	☐ $116.00
School Time	☐ $30.00
Dental Accident Insurance (with either of the above plans)	☐ $8.50

Make checks payable to:

American Management Advisors, Inc.

How to Enroll

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 American Management Advisors – PO Box 366 – Langhorne, PA 19047. 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.)

BACC-004-0909

MEDICAL CLAIM FORM

1. COMPLETE THIS FORM
2. ATTACH ALL BILLS
3. MAIL TO

MCA ADMINISTRATORS, INC.

P.O. BOX 6540

HARRISBURG, PA 17112

ADMINISTRATOR FOR AMERICAN MANAGEMENT ADVISORS

CLAIM ASSISTANCE:
1-800-427-9308

IF PART A AND PART B ARE NOT COMPLETED *IN FULL* THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED.

BEFORE COMPLETING THIS FORM REFER TO CLAIM PROCEDURES AS THEY APPEAR ON THE BACK OF THIS MEDICAL CLAIM FORM

PART A. POLICY HOLDER

(1) Name of School District/College/Organization	Individual School/Team	(2) County

(3) Address of School: (Street)	(City)	(State)	(Zip)	(4) Area Code - Telephone #	(5) Date of Injury MO DAY YR

(6) Name of Injured Person	(7) Date of Birth MO DAY YR	(8) Social Security #	(9) Age	(10) Grade	(11) MALE ☐ FEMALE ☐

(12) Injury occurred: Practice ☐ Game ☐ P.E. ☐ Travel ☐ Classroom ☐
At Home ☐ Intramural ☐ Interscholastic ☐ Intercollegiate ☐

(13) Type of Sport:

(14) Describe in detail HOW the injury occurred. NOTE: If your school uses an accident report form, please attach a copy of the report.

(15) What part of the body was injured:
(Left or Right side if applicable)

(15a) Time of injury ____:____a.m. ____:____p.m.

(16) At the time of the accident, was the injured person involved in an activity under the jurisdiction of the policyholder? Yes ☐ No ☐

(17) Name of Supervisor (If different from organization official)

(18) Was he/she a witness to accident? Yes ☐ No ☐

(19) Signature of School or Organization Official	(20) Title of Official	(21) Date Signed MO DAY YR

PART B. PARENT, RESPONSIBLE PARTY OR GUARDIAN STATEMENT

(1) Name of Mother/Father or Guardian	(2) Social Security #	(3) Relationship to insured ☐ Father Guardian ☐ Mother Self

(4) Address (Number) Street (Lot or Apt. No.)	(5) City	(6) State	(7) Zip Code

(8) Area Code – Home Telephone Number

(9) Father's work telephone ( ) _____
Mother's work telephone () _____

(10) Occupation of Father or Mother, Wife or Husband	(11) Place of Employment	(12) Address of Employer

(13) Occupation of Self (if over age 18)	(14) Place of Employment	(15) Address of Employer

(16) Do you have any other health and/or accident insurance plan (other than this plan?)
Father: ☐ YES ☐ NO Mother: ☐ YES ☐ NO Husband: ☐ YES ☐ NO Wife: ☐ YES ☐ NO Self: ☐ YES ☐ NO

(17) Is the injured person covered by other health and/or accident insurance plan?
☐ YES ☐ NO Effective Date MO DAY YR

(18) Name of other health and accident insurance company

(19) Address of Insurance Company	(20) Policy Number	Phone #

BY SIGNING BELOW I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, government agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representative any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person who death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administration to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage the Policy identified above and that a copy of this Authorization shall be considered as valid as the original.
I agree that a photographic copy of this authorization shall be valid as the original.
I understand that I or my authorized representative may request a copy of this authorization.
I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to intent to revoke.

Signature of Insured or Authorized Representative — Dated

Address

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I authorize payment of Medical payments to Physician or Supplier for Services described on the reverse side and/or attached.

Date — Signature of Responsible Party or Student if 18 years old

CLAIM PROCEDURES

1. Submit all itemized bills to both your family insurance carrier and the insurance carrier for your school/organization. These bills are generally a HICFA form (Physician) or a UB92 form (Hospital). The Physician or Hospital has an assignment of Benefits on file; which was completed on the initial treatment visit. This assignment of Benefits will be honored. If your Provider does not bill on a HICFA or UB92 Form, You will need to sign the authorization to pay Benefits to the Provider on the front of this form.

2. If your family insurance carrier is an HMO organization, CONTACT YOUR HMO PHYSICIAN AT ONCE. FAILURE TO DO SO MAY RESULT IN THE CLAIM BEING DENIED OR A SUBSTANTIALLY REDUCED BENEFIT.

3. Your family insurance carrier will send you an Explanation of Benefits (E.O.B.) listing the payments made by them. Upon receipt of the E.O.B., forward the E.O.B. along with any unpaid itemized bills and a completed claim form to the claim administrator: MCA Administrators, Inc. for processing: paid receipts and/or balance due statements are not accepted.

4. If you do not have other valid and collectible insurance (Auto, Employer Provided, Family Insurance or Self-Provided): complete the information on the claim form, sign where indicated, include all your itemized bills, receipts, etc., and forward to the claim administration for processing.

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

THINGS TO REMEMBER

1. TO SUBMIT ADDITIONAL BILLS AFTER THE ORIGINAL FORM HAS BEEN SENT IN, BE SURE TO INCLUDE THE FOLLOWING: (A) NAME OF CLAIMANT; (B) DATE OF ACCIDENT; (C) NAME OF THE POLICYHOLDER (SCHOOL, COLLEGE OR ORGANIZATION).

2. IF YOUR FAMILY INSURANCE CARRIER IS AN HMO ORGANIZATION, CONTACT YOUR HMO PHYSICIAN AT ONCE.

3. 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.

4. AUTHORIZATION TO RELEASE MEDICAL INFORMATION (MUST BE SIGNED)

5. PAYMENT WILL BE MADE TO THE SOURCE OF SERVICE (HOSPITAL, PHYSICIAN, ETC.) UNLESS CLAIM FORM ACCOMPANYING THE BILL INDICATES OTHERWISE AT THE TIME THE CLAIM IS SUBMITTED. IF YOU PAID FOR THE SERVICES AND REIMBURSEMENT IS TO BE PAID TO YOU, PROOF OF PAYMENT WILL BE REQUIRED AT THE TIME THE CLAIM IS SUBMITTED.