UP TO $25,000 STUDENT ACCIDENT MEDICAL INSURANCE PROTECTION

ADMINISTERED BY:

Lefebvre Insurance, LLC
850 Franklin Street
Wrentham, MA 02093
(800) 451-9668

2020-2021

Underwritten By:
AXIS Insurance Company

SI_K12_RI_2020-2021

24 HOUR ACCIDENT COVERAGE

Provides accident coverage for the full 24 hours of the day, not only during school hours, but also at home or on weekends, during vacation periods, at camp, anytime, anywhere when school is not in session. SEE EXCLUSIONS.

Full Time, Registered Student K-12, Teachers, Administrative and Other Personnel $75.00

SCHOOL TIME ACCIDENT COVERAGE

Provides coverage while in attendance at school during the hours and on the days that school is in session. Includes traveling directly and without interruption to or from the Insured's residence and the school for regular school session, for such travel time as is required, but not to exceed one hour after school is dismissed, or if additional travel time on the school bus is required, coverage here under shall extend for such additional travel time as might be necessary. Participation in or attending an activity exclusively organized, sponsored and solely supervised by the school and whileunderthesupervisionofschoolemployees. Travelislimited to school supervised transportation. SEE EXCLUSIONS.

Full Time, Registered Student K-12,
Teachers, Administrative and Other Personnel $20.00

CONDITIONS

The accident must be reported immediately to a school authority under the School Time Coverage. Under the 24 Hour Coverage report the accident to the school or Lefebvre Insurance (the address is below). The claim form must be filed with the Company within 90 days after the accident. Covered Excess Expenses must be incurred within 90 days from the date of accident. Related expenses are eligible for up to two years from the date of accident. A claim for those Covered Expenses must be submitted to the Company for payment as soon as reasonably possible, but no later than one year from the date of service. It is the parent's responsibility to file the claim form within 90 days.

Direct All Questions and Correspondence To:

LEFEBVRE INSURANCE, LLC
850 Franklin Street
Wrentham, MA 02093
(800) 451-9668

This brochure is not a contract. It is simply an illustration of benefits. You may read the master policy at the school district office. You will not receive an Individual Accident Policy. Keep your cancelled check, as it is proof of purchase. **DO NOT SEND CASH.**

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

$2,500 Interscholastic Tackle Football Accident Plan

Covers only seniorhigh interscholastic tackle football,grades 9-12. Coverage beginswhen official practice is allowed or when payment for the coverage is received, whichever is later, and ends on the last day of the football season

Interscholastic Football Only $50.00

OPTIONAL $50,000.00 Extended Dental Benefit

When this option is purchased, the basic dental benefit will be extended to provide for the Usual & Customary Charges for Dental Treatment of a Dental Injury expenses incurred within 2 years from the date of the Covered Injury. Also included in this benefit are the following:

1. Dental Treatment means 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 & Customary Charge normally made by a Dentist for necessary treatment actually rendered during the 104-week period immediately following the date of Covered Injury; if there is more than one way to treat a dental problem, the Company will pay benefits for the least expensive procedure provided that this meets acceptable dental standards.
3. If the Insured's Dentist certifies, in writing to the Claim Administrator, that treatment must be deferred until after two (2) years from the date of the Accident, a maximum of $800.00 will be paid. Deferred Treatment must be completed within two (2) years of the expiration of the Initial Treatment Period. No bills will be paid without written certification. Services must commence within 90 days from the date of the Covered Injury. This benefit is in effect 24 hours a day, even when purchased with School Time Coverage.

Full Time, Registered Student K-12,
Teachers, Administrative and Other Personnel $9.00
This coverage **cannot** be purchased without School Time or 24 Hour coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT

When Injury shall result in anyone of the following losses within 180 days from the date of accident, the company will pay for loss of:

Life $5,000
($15,000 for a death under the Sports Condition of Coverage)
Both hands or both feet or the entire
sight of both eyes $20,000
One Hand and One Foot $20,000
Either One Hand or One Foot and the
Entire Sight of One Eye $20,000
One Hand or One Foot or the
entire sight of one eye $10,000

"Loss" of a hand or foot means complete severance through or above the wrist or ankle joint. "Loss" of sight of an eye means total and irrecoverable loss of the entire sight in that eye. "Loss" of thumb or index finger means complete severance through or above the metacarpophalangeal joint of both digits. If more than one Loss is sustained by an Insured as a result of the same accident, only one amount, the largest, will be paid.

Effective & Termination Date

Coverage begins at 12:01 AM on the date the School receives a completed application and payment of premium. Otherwise, coverage begins on the day of receipt of the application and the first official day of school or the first official practice of interscholastic athletics/activities.

The coverage terminates on the date the Insured ceases to be a registered student or the termination date of the policy, whichever occurs first. If the student, teacher, or administrative employee moves or transfers to another Public or Parochial Day School, the student, teacher, or administrative employee will be covered at the new school until this policy expires. If the premium check is returned from the bank for any reason, the coverage is null and void.

All other coverages end when School begins regularly scheduled classes for the following School term.

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 Rhode Island under form number BACC-001-0909. 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 $25,000 MEDICAL EXPENSE

The company will pay Usual and Customary Expenses incurred for a covered Injury if treatment is received within 90 days after the Injury. The Schedule of Benefits are stated below. Benefits are payable for 52 weeks from the date of the Injury.

MAXIMUM BENEFITS
Senior High Football Injury Limited to $2,500
Hospital Services:
Daily Room & Board (Semi-private) . Avg. Semi-Private Rate
Intensive Care Room & Board . . . . . Usual & Customary

Miscellaneous Services:
During Hospital Confinement or when
surgery is performed . . . . . Usual & Customary
Emergency Room out-patient: when Hospital
Confinement is not required . . . . . $300 Max
Doctor's Services:
Surgery, including pre and post operative care - Usual & Customary Expenses in accordance with the 1974 Revised California Relative Value Study, 5th Edition, having a conversion factor of $150 unit value to $1,000 Max
Anesthesia: (including administration) and assistant surgeon: (% of surgical allowance) . . . Usual & Customary
Doctor Visits other than for Physiotherapy
or similar treatment when no surgery
benefit is paid . . . . . $60 for the 1st visit, $40 thereafter
Consultants (when required by attending physician for confirmation or determining a diagnosis, but not for treatment) and second opinion: . . . . . Usual&Customary

Laboratory & X-Ray Services:
Other than Dental and including fee for
interpretation and/or reading of X-Ray
X-ray when not Hospital Confined X-ray .Usual & Customary
Lab . . . . . Usual & Customary
MRI's, CAT Scans, Laser Treatments or similar
procedures, including fee for interpretation
and/or reading . . . . Usual & Customary up to a max of $600

Additional Services:
Physiotherapy or similar treatment:
In-Hospital . $60 for the 1st visit, $40 thereafter up to 5 days
Out of Hospital . . . . . $60 for the 1st visit, $40 thereafter
up to 5 days
Chiropractic Services (in or out of hospital) $100.00
Registered Nurse (in or out of hospital) . Usual & Customary
Ambulance to initial treatment facility . . Usual & Customary
Orthopedic Appliances:
In-hospital $1,500
Out of Hospital $1,500
Outpatient Drugs & Medication:
Administered by a Doctor . . . . . Usual & Customary
Eyeglasses, Contact Lenses and Hearing Aids; replacement of broken eyeglasses and/or frames, contact lenses, hearing aids, resulting from a covered Injury $750.00

Dental Services:
For treatment, repair or replacement of
Injured natural teeth, includes initial braces when required for treatment of a covered Injury, as well as examinations, x-rays, restorative treatment, endodontics, oral surgery, and treatment for gingivitis
resulting from trauma . . . Usual & Customary, Max $10,000

FULL EXCESS COVERAGE
Benefits are payable for Medically Necessary covered expenses that are in excess of amounts payable under any Other Health Care Plan and are subject to the applicable Total Maximum for all Accident Medical Benefits. If the Insured is not covered by any Other Health Care Plan providing Accident Medical Benefits, the excess provision shall not apply, and benefits are payable to the total Maximum for all Accident Medical Benefits as shown in your Master Insurance Application.

EXCLUSIONS AND LIMITATIONS
Exclusions: The policy does not cover any loss incurred as a result of:

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 Accident that occurred while the Insured Person was riding in or driving a Motor Vehicle. Benefits will not exceed the Benefit Limit shown in the Schedule of Benefits.

Excluded Expenses

For the purposes of this Accident Medical Benefit, 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 Injury;
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.
5. treatment of injuries that result over a period of time (such as blisters, tennis elbow, etc.), and that are a normal, foreseeable result of participation in the Covered Activity (does not apply to Voluntary Coverage) (does not apply if Expanded Sports Medical Coverage is Selected on the Master Application); or
6. treatment of an injury resulting from or contributed to by frostbite, fainting or seizures, or heatstroke or heat exhaustion (does not apply to Voluntary Coverage) (does not apply if Expanded Sports Medical Coverage is Selected on the Master Application).

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. 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 theloss results directly or non directly from thetreatment except for any bacterial infection resulting from an Accidental external cut or wound or Accidental ingestion of contaminated food;
9. A cardiovascular, event or stroke resulting,directly and independently of all other causes,from exertion, as verified by a Physician,while the Insured Person participates in a Covered Activity (does not apply to Voluntary Coverage) (does not apply if Expanded Sports Medical Coverage is Selected on the Master Application);
10. 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;
11. injuries compensable under Workers' Compensation law or any similar law;
12. 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;
13. 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;
14. 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;
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.

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. Full terms and conditions of coverage, including effective dates of coverage, benefits, limitations, and exclusions, are set forth in the policy.

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TO FILE A CLAIM:

1. Use attached claim form
2. Fill out all necessary information
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

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.
- ☐ **PLEASE RETURN THE COMPLETED ENROLLMENT FORM (EVEN IF DECLINING COVERAGE) TO YOUR SCHOOL.** (Your cancelled check or money order stub will serve as proof of payment.)

FOR QUESTIONS, INQUIRIES, AND INFORMATION CONTACT:

Lefebvre Insurance, LLC
850 Franklin Street
Wrentham, MA 02093
(800) 451-9668

DO NOT SEND CASH

ENROLLMENT FORM

Please Print 2020-2021

STUDENT'S LAST NAME

STUDENT'S FIRST NAME MIDDLE INITIAL

BIRTH DATE (MM/DD/YYYY) GRADE PHONE

HOMEADDRESS APT#

CITY STATE ZIP

SCHOOL SYSTEM/DISTRICT

SCHOOLNAME

FRAUD WARNING:

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.

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
24-Hour – Including Extended Dental	☐ $84.00
24 Hour Only	☐ $75.00
School Time – Including Extended Dental	☐ $29.00
School Time Only	☐ $20.00
Interscholastic Football Only (Grades 9-12)	☐ $50.00

Make checks payable to AXIS Insurance Company

HOW TO ENROLL

1. Decide whether you want the School Time, 24-Hour Accident Protection (with or without Dental).
2. Fill out the enrollment form and enclose the form along with a check or money order made payable to AXIS Insurance Company for the correct amount.
3. **Return the completed enrollment form and payment to your School.** 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.)

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

MCA Administrators, Inc
PO Box 6540
Harrisburg, PA 17112
Phone: 1-800-427-9308
Fax: 717-652-8328
Email: student-insurance@mcoa.com

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:** _____

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 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.

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.

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