

Aldine ISD Voluntary Student Accident Plans

AT SCHOOL COVERAGE

Plan A \$ 50.00

Plan B \$ 38.00

Voluntary Grades PK-12

- (a) while on the School premises: during the hours and on the days School is in regular session, and during the hours and on the days when School is not in session while the Insured Person is participating in or attending any Sponsored and Supervised School Activity (excluding Senior High school interscholastic football); and
- (b) while away from the School premises: other than traveling, if participating in a Sponsored and Supervised School Activity (excluding Senior High school interscholastic football); and
- (c) while traveling directly to or from the Insured Person's residence and School: for regular School sessions, or for any Sponsored and Supervised School Activity in School designated vehicle (excluding Senior High school interscholastic football).

24 HOUR COVERAGE

Plan A \$ 174.00

Plan B \$ 132.00

Voluntary Grades PK-12

Coverage is in force for each person for whom the 24-Hour Coverage premium has been paid as set forth in the Policy on a twenty-four (24) hour per day basis (excluding Senior High school interscholastic football).

MEDICAL PAYMENTS

The policy provides Full Excess Medical Expense benefits for loss due to a Covered Injury up to the Total Maximum for all Accident Medical Benefits of \$25,000 for each Covered Accident. 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 Medical Expenses incurred within 104 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. Artificial limbs, artificial eyes or other prosthetic appliances are covered expenses.

Full Excess Medical Expense means the Company will pay the Medically Necessary Covered Expenses after the Insured Person satisfies any Deductible; and only when they are in excess of amounts payable by any Other Health Care Plan whether or not claim has been made for benefits it provides. The Company will pay benefits without regard to any Coordination of Benefits provision in such Other Health Care Plan.

Schedule of Benefits for Voluntary Student Accident Plans

These benefits are paid up to the following maximums, not to exceed \$25,000 for each injury once the \$100 corridor deductible has been met.

| COVERED EXPENSES | Plan A | Plan B |
|---|---|---|
| In-Patient Hospital Services | 90% of U&C Charges | 70% of U&C Charges |
| Hospital Miscellaneous Expenses | 90% of U&C Charges | 70% of U&C Charges |
| Nurse Services | 90% of U&C Charges | 70% of U&C Charges |
| Orthopedic Appliances Outpatient | 90% of U&C Charges | 70% of U&C Charges |
| Emergency Room Treatment | 90% of U & C Charges up to \$2,000 per Covered Injury | 70% of U & C Charges up to \$2,000 per Covered Injury |
| Ambulatory Medical Center | 90% of U & C Charges up to \$2,000 per Covered Injury | 70% of U & C Charges up to \$2,000 per Covered Injury |
| Physician Services Surgery | 90% of U&C Charges | 70% of U&C Charges |
| Assistant Surgeon | 90% of U&C Charges | 70% of U&C Charges |
| Use of Phy's Surgical Facilities | 90% of U&C Charges | 70% of U&C Charges |
| Anesthesia and its Administration | 90% of U&C Charges | 70% of U&C Charges |
| In-Hospital Visits | 90% of U&C Charges | 70% of U&C Charges |
| Office Visits | 90% of U&C Charges | 70% of U&C Charges |
| Out Patient X-Ray | 90% of U&C Charges | 70% of U&C Charges |
| Out Patient CT Scan, MRI | 90% of U&C Charges | 70% of U&C Charges |
| Out Patient Laboratory Tests | 90% of U&C Charges | 70% of U&C Charges |
| Out Patient Physiotherapy | 90% of U&C Charges up to \$50 per visit up to a maximum of 5 visits | 70% of U&C Charges up to \$50 per visit up to a maximum of 5 visits |
| Ambulance Services | 90% of U&C Charges not to exceed \$800 | 70% of U&C Charges not to exceed \$800 |
| Medical Equipment Rental | 90% of U&C Charges | 70% of U&C Charges |
| Dental Services | 90% of U&C Charges not to exceed \$500 | 70% of U&C Charges not to exceed \$500 |
| Motor Vehicle Injury | 90% of U&C Charges | 70% of U&C Charges |
| Prescription Drugs (Out Patient) | 90% of U&C Charges | 70% of U&C Charges |
| Eyeglasses, Contact Lenses, Hearing Aids | 90% of U&C Charges | 70% of U&C Charges |
| Deferred Dental Expense Benefit | 100% of U&C Charges up to \$600 | 100% of U&C Charges up to \$600 |

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

ALD-ISD MMC-Vol_07.16_v1_BACC

ENROLL ONLINE FOR QUICKER SERVICE or COMPLETE AND MAIL SCHOOL YEAR 2016-2017

⇒ Student's First Name _____

M Last Name _____

Birth Date / /

⇒ Address _____

City _____ ST _____ Zip _____

Phone _____ - _____

⇒ **Aldine ISD** Name of School _____ Grade _____

| | | | |
|--|---|--|---|
| Plan A School Time Coverage <input type="checkbox"/> \$ 50.00 | Plan A 24 Hour Coverage <input type="checkbox"/> \$ 174.00 | Plan B School Time Coverage <input type="checkbox"/> \$ 38.00 | Plan B 24 Hour Coverage <input type="checkbox"/> \$ 132.00 |
|--|---|--|---|

Complete for MASTERCARD VISA Name on Card, Last _____ First _____

Card Number _____ Expiration Date Mo _____ Year _____

Cardholder Signature _____ Date _____



Aldine ISD Voluntary Student Accident Plans

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 Covered Conditions section of the Policy:

1. Intentionally self-inflicted injury, suicide, or auto-eroticism 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. Release, whether or not accidental, or by any person unlawfully or intentionally, of nuclear energy or radiation, including sickness or disease resulting from such release;
6. A Covered Loss that occurs while on active duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, the Company will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days;
7. Flight in, boarding or alighting from, an Aircraft or any craft designed to fly above the Earth's surface:
 - a. except as a fare-paying passenger on a regularly scheduled commercial airline;
 - b. being flown by the Insured Person or in which the Insured Person is a member of the crew;
 - c. being used for any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
 - d. designed for flight above or beyond the earth's atmosphere;
 - e. including an ultra-light or glider;
 - f. being used for the purpose of parachuting or skydiving;
 - g. being used by any military authority, except an Aircraft used by the air mobility command or its foreign equivalent;
8. Travel in any Aircraft owned, leased 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;
9. bungee-cord jumping, parachuting, skydiving, parasailing, hang-gliding;
10. 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;
11. Medical or surgical treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice unless it occurs during treatment of injuries sustained in a Covered Injury;
12. 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;
13. 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
14. 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 officers report, or similar items will be considered proof of the Insured Person's intoxication;
15. Operating any type of vehicle or conveyance while under the influence of alcohol or any drug, narcotic 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.
16. Travel in or on any on-road and off-road motorized vehicle except a golf cart or other vehicle the Company specifically agrees to cover, that does not require licensing as a motor vehicle;
17. Participation in any motorized race or contest of speed;
18. 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;
19. Injuries compensable under Workers' Compensation law or any similar law
20. Participation in any sports activity not specifically authorized, sponsored and supervised by the School, whether or not it takes place on School premises or during normal School hours, during a Covered Activity, including but not limited to snowboarding, skateboarding, motorcycle racing, racing rocket-powered, jet propelled or nuclear-powered vehicles;

21. Participation in any team sport or any other athletic activity, except participation in a Covered Activity.

In addition, benefits will not be paid for services or treatment rendered by any person who is:

1. employed or retained by the Policyholder;
2. living in the Insured Person's household;
3. an Immediate Family Member including Eligible Domestic Partner of either the Insured Person or the Insured Person's spouse; or
4. the Insured Person.

Excluded Expenses

The following will not be considered Covered Expenses unless coverage is specifically provided.

1. Blood, blood plasma, or blood storage, except expenses by a Hospital for processing or administration of blood.
2. Cosmetic surgery, except for reconstructive surgery needed as the result of a Covered Loss.
3. 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.
4. Examination or prescriptions for, or purchase, repair or replacement of, eyeglasses, contact lenses, hearing aids, wheelchairs, braces, appliances, orthopedic braces, or orthotic devices.
5. Treatment in any Veteran's Administration, Federal, or state facility, unless there is a legal obligation to pay.
6. Services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay.
7. Rest cures or custodial care.
8. Repair or replacement of existing dentures, partial dentures, braces or bridgework.
9. Personal services such as television and telephone or transportation.
10. Orthopedic appliances used mainly to protect an Injury so that the Covered Person can take part in interscholastic and club sports.
11. Expenses payable by any automobile insurance policy without regard to fault.
12. 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.
13. Repair or replacement of existing artificial limbs, eyes and larynx.
14. Charges for any article of clothing intended for use more than once

Accidental Death & Dismemberment Benefits (Within 180 Days)

| | |
|--|-----------------|
| Loss of Life..... | \$15,000 |
| Heart Failure..... | \$10,000 |
| Loss of Two or More Hands or Feet..... | \$30,000 |
| Loss of Sight of Both Eyes..... | \$30,000 |
| Loss of One Hand or One Foot and Sight in One Eye..... | \$30,000 |
| Loss of One Hand and Foot..... | \$30,000 |
| Loss of Sight in One Eye..... | \$15,000 |
| Loss of One Hand or Foot..... | \$15,000 |
| Loss of Thumb and Index Finger of Either Hand..... | \$7,500 |
| Exposure and Disappearance..... | Included |

How to File a Claim

1. This claim form should be fully completed and submitted within 90 days from the date of accident. Be sure to answer and complete the section regarding "OTHER INSURANCE STATEMENT".
2. Please advise all doctors/hospitals regarding this coverage so they may forward us their itemized bills. However, if you have already been to the doctor/hospital and did not know about this coverage, then please send all of the itemized bills to the address shown below.
3. The bills should include the name of the doctor/hospital, their complete mailing address, telephone number, the date you were seen by the doctor/hospital, what the doctor saw you for (diagnosis) and the specific itemized charges (description of treatment and amount) incurred (including the CPT/procedure code). If this information is not on the bill, we will have to contact the doctor/hospital which will delay the review of your claim. "Balance Due" or "Balance Forward" statements do not contain sufficient information to complete your claim.
4. Only one claim form per accident needs to be submitted. Once completed, make a photocopy for your records, and mail to: **WebTPA: P.O. Box 669; Grapevine, TX 76099-0669; or call 1-877-563-7492 for assistance.**

ALD-ISD MMC-Vol 07.16 v1_BACC

Enrollment Options

- ◆ Complete and detach the enrollment form.
- ◆ Make Checks or money order payable to Texas Monarch Management Corp. Do Not Send Cash. Credit card payment is also accepted.
- ◆ Clearly print name of child on the check or money order.
- ◆ Send the enrollment form and payment to:
Monarch Management Corp.
3201 Cherry Ridge Drive, Suite D405, San Antonio, TX 78230
- ◆ Your cancelled check, money order stub or credit card statement is your proof of purchase.
- ◆ Keep this for your reference, you will receive no policy.
- ◆ If you have questions about this coverage, please call:
Monarch Management Corp. 1-800-662-2778.



Underwritten by AXIS Insurance Company

Offered by:



Enroll Online at www.mmc-ins.com